Filing at a Glance

Company:	All Savers Insurance Company
Product Name:	Individual Health
State:	Indiana
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005A Individual - Preferred Provider (PPO)
Filing Type:	Form/Rate
Date Submitted:	05/09/2014
SERFF Tr Num:	UHLC-129514067
SERFF Status:	Closed-Approved
State Tr Num:	IEXPOL.I.15.IN
State Status:	
Co Tr Num:	IEXPOL.I.15.IN
Implementation Date Requested:	11/15/2014
Author(s):	Jamie Shallow, Lindsay Fisher, Michelle Peters, Matt Genal, Debra Paris, Lori Moline, Patricia Allison, Anna Ferrell, Cindy Newell, Sophia Bolle
Reviewer(s):	Kim Isles (primary), Karl Knable
Disposition Date:	08/08/2014
Disposition Status:	Approved
Implementation Date:	01/01/2015

State Filing Description:

State: *Indiana* **Filing Company:** *All Savers Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Individual Health*
Project Name/Number: *IEXPOL.I.15.IN/IEXPOL.I.15.IN*

General Information

Project Name: IEXPOL.I.15.IN
Project Number: IEXPOL.I.15.IN
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Lindsay Fisher

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 08/08/2014
State Status Changed:
Created By: Patricia Allison
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: On Exchange. Not marketed Off-Exchange, but available upon request. Policy amendment and enrollment form are attached for use when requested Off-Exchange only.

Filing Description:

On behalf of All Savers Insurance Company, I am submitting the enclosed Individual Exchange Products for your Department's review and approval. These forms incorporate the requirements for essential health benefits as required under the Patient Protection and Affordable Care Act (PPACA).

These plans are intended for use ON-Exchange in the federally facilitated marketplace. These plans will not be actively marketed off-exchange. However, as required by federal law, these forms must be available on an off-exchange basis if requested . In light of this requirement, we are including Amendment 15AMD-IEX-OX.IN and enrollment form IND.ENROLL.14.IN 5/14 to be used only in the event that an applicant should request one of these plans off-exchange.

Explanation of Variable Text -
Included in these forms are the following features:
•Non-variable Text that always appears in an issued document.
•Variable Text that may or may not appear in an issued document depending on the specific product and plan design selected by the Policyholder. Variable text is enclosed in [brackets].
•Instruction text that is included, where necessary, to further explain the variability in the filed forms. Please note that any instruction text will appear only in the filed form and will not appear in the form issued to a Policyholder.

If you have any questions or concerns regarding this submission, please feel free to call me at 800-926-7602, extension 77771 or email me at dlparis@unitedhealthone.com.

Company and Contact

Filing Contact Information

Debra Paris, Manager
7440 Woodland Drive
Indianapolis, IN 46278

dlparis@unitedhealthone.com
800-926-7602 [Phone] 7771 [Ext]
317-328-9645 [FAX]

State: *Indiana* ***Filing Company:*** *All Savers Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Individual Health*
Project Name/Number: *IEXPOL.I.15.IN/IEXPOL.I.15.IN*

Filing Company Information

All Savers Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278
(800) 926-7602 ext. [Phone]

CoCode: 82406
Group Code: 707
Group Name:
FEIN Number: 35-1665915

State of Domicile: Indiana
Company Type: Life and Health
State ID Number: 82406

Filing Fees

Fee Required? Yes

Fee Amount: $700.00

Retaliatory? Yes

Fee Explanation: $35.00 per Form x 19 forms = $665.00
$35.00 for Rate Filings x 1 rate filing = $35

$665 + 35 = $700.00

Fees are capped at $1,000.00 per filing.

Per Company: Yes

Company	Amount	Date Processed	Transaction #
All Savers Insurance Company	$700.00	05/09/2014	82099895

State: Indiana **Filing Company:** All Savers Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Individual Health
Project Name/Number: IEXPOL.I.15.IN/IEXPOL.I.15.IN

Form Schedule

Lead Form Number: IEXPOL.I.15.IN

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Policy	IEXPOL.I.15.IN	POL	Initial		50.200	IN IEX Policy Revised 080414.pdf
2		Schedule of Benefits – Plan Gold Choice 1250 and Gold Choice 1250-1	SBN.IEX.CHC.I.15.IN.G.1250	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN G 1250.pdf
3		Schedule of Benefits – Plans Silver Choice HSA 2600 and Silver Choice HSA 2600-1	SBN.IEX.CHC.I.15.IN.S.HSA.2600	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 2600.pdf
4		Schedule of Benefits – Plan Silver Choice HSA 1900	SBN.IEX.CHC.I.15.IN.S.HSA.1900	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 1900.pdf
5		Schedule of Benefits – Plan Silver Choice HSA 550	SBN.IEX.CHC.I.15.IN.S.HSA.550	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 550.pdf
6		Schedule of Benefits – Plan Silver Choice HSA 75	SBN.IEX.CHC.I.15.IN.S.HSA.75	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 75.pdf
7		Schedule of Benefits – Plans Silver Choice 3500 and Silver Choice 3500-1	SBN.IEX.CHC.I.15.IN.S.3500	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S 3500.pdf
8		Schedule of Benefits – Plans Silver Choice 5000 and Silver Choice 5000-1	SBN.IEX.CHC.I.15.IN.S.5000	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S 5000.pdf
9		Schedule of Benefits – Plans Silver Choice 2000 and Silver 2000-1	SBN.IEX.CHC.I.15.IN.S.2000	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S 2000.pdf

SERFF Tracking #: UHLC-129514067 **State Tracking #:** IEXPOL.I.15.IN **Company Tracking #:** IEXPOL.I.15.IN

State: Indiana **Filing Company:** All Savers Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Individual Health
Project Name/Number: IEXPOL.I.15.IN/IEXPOL.I.15.IN

Lead Form Number: IEXPOL.I.15.IN

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
10		Schedule of Benefits – Plan Silver Choice 2500	SBN.IEX.CHC.I.15.IN.S.2500	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S 2500.pdf
11		Schedule of Benefits – Plan Silver Choice 3500-2	SBN.IEX.CHC.I.15.IN.S.3500-2	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S 3500-2.pdf
12		Schedule of Benefits – Plan Silver Choice 1200	SBN.IEX.CHC.I.15.IN.S.1200	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S 1200.pdf
13		Schedule of Benefits – Plans Silver Choice 250, Silver Choice 250-1, and Silver Choice 250-2	SBN.IEX.CHC.I.15.IN.S.250	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S 250.pdf
14		Schedule of Benefits – Plans Silver Choice 100, Silver Choice 100-1, and Silver Choice 100-2	SBN.IEX.CHC.I.15.IN.S.100	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN S 100.pdf
15		Schedule of Benefits – Plans Bronze Choice HSA 4900 and Bronze Choice HSA 4900-1	SBN.IEX.CHC.I.15.IN.B.HSA.4900	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN B HSA 4900.pdf
16		Schedule of Benefits – Plans Bronze Choice 5500 and Bronze Choice 5500-1	SBN.IEX.CHC.I.15.IN.B.5500	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN B 5500.pdf
17		Schedule of Benefits – Plans, Gold Choice $0, Silver Choice HSA $0, Silver Choice $0, Silver Choice $0, Silver Choice $0, Bronze Choice HSA $0, and Bronze Choice $0	SBN.IEX.CHC.I.15.IN.AI.0	SCH	Initial		54.100	FV5 - IN IEX Schedule SBN IEX CHC I 15 IN AI 0.pdf

SERFF Tracking #:	*UHLC-129514067*	***State Tracking #:***	*IEXPOL.I.15.IN*	***Company Tracking #:***	*IEXPOL.I.15.IN*

State:	*Indiana*	***Filing Company:***	*All Savers Insurance Company*
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Product Name:	*Individual Health*		
Project Name/Number:	*IEXPOL.I.15.IN/IEXPOL.I.15.IN*		

Lead Form Number: IEXPOL.I.15.IN

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
18		Member Enrollment Form	IND.ENROLL.14.IN 5/14	AEF	Initial		0.000	IND.ENROLL.14.IN 5-14, Member Enrollment Form.pdf
19		Amendment-IEX-2015-Off Exchange-IN	15AMD-IEX-OX.IN	POLA	Initial		0.000	Amendment-IEX-2015-Off Exchange-IN 072514 .pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

All Savers Insurance Company

Choice Individual Medical Policy

[7440 Woodland Drive

Indianapolis, Indiana 46278-1719]

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if: (A) we do not receive premiums when due, as described in the Policy; (B) a Covered Person has committed an act of fraud or made an intentional misrepresentation in connection with the Policy; (C) we discontinue offering and refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live; or (D) we discontinue offering and refuse to renew all individal policies/certificates in the individual market in the state where you reside. Please refer to Events Ending Your Coverage for further information.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

30-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 30 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

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

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

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

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

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

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

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

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

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

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

Don't Hesitate to Contact Us

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

Your Responsibilities

Be Enrolled and Pay Required Premiums

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

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

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

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

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

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

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

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

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

1. Ambulance Services

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

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

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

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

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

3. Diabetes Services

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

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

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

Diabetic Self-Management Items

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

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

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

- Not of use to a person in the absence of a disease or disability.

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

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

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

Benefits are available for repairs and replacement, except that:

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

5. Emergency Health Services - Outpatient

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

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

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

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

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

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

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

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

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

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

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

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

9. Lab, X-Ray and Diagnostics - Outpatient

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

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

Benefits under this section include:

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

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

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

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

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

Benefits under this section include:

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

11. Mental Health Services

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

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

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

12. Pharmaceutical Products - Outpatient

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

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

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

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

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

13. Physician Fees for Surgical and Medical Services

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

14. Physician's Office Services - Sickness and Injury

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

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

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

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

Benefits under this section include allergy injections.

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

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

15. Pregnancy - Maternity Services

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

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

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

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

16. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by calling *Customer Care* at 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.
  - Duration of a rental.
  - Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

17. Prosthetic Devices

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

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

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

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

Benefits are available for repairs and replacement, except that:

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

18. Reconstructive Procedures

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

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

to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

19. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

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

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

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

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

20. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

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

Benefits under this section include:

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

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

21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

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

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

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

22. Substance-Related and Addictive Disorders Services

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

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

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

23. Surgery - Outpatient

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

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

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

Benefits under this section include:

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

24. Therapeutic Treatments - Outpatient

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

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

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

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

Benefits under this section include:

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

25. Transplantation Services

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

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

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

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

26. Urgent Care Center Services

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

Additional Benefits Required By Indiana Law

27. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

28. Autism Spectrum Disorder Services

Benefits for Autism Spectrum Disorders will be provided on the same basis as any other Sickness for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by your treating Physician. The written treatment plan is subject to medical necessity requirements. If we deny the medical necessity of any service recommended by your Physician in the written treatment plan, you may appeal our decision by following the procedures detailed in Section 6.

An exclusion within the Policy that is inconsistent with the treatment plan will be waived to the extent of any conflict. We may require your Physician to submit an updated treatment plan every six months.

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

29. Cancer Chemotherapy

Covered Health Services include chemotherapy for the treatment of cancer, whether administered orally, intravenously or by injection.

30. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.

- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

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

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

31. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

32. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.

- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

33. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

34. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

35. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

36. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

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

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

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

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

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

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

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

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

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

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

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

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

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

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

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

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

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

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

Pre-Treatment Estimate

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

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

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

Pre-Authorization

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

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

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

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

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

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

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

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly associated with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

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

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

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

Frequency of Service Limits

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

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

Eyeglass Lenses

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

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

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

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

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

Contact Lenses

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

Benefits include the fitting/evaluation fees and contacts.

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

Necessary Contact Lenses

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

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

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

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

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

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

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

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

- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

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

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

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

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

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

   Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:

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

5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.

7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.

8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

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

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

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

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

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

   Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

   - The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
   - The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

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

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

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

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

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

12. Unit dose packaging or repackagers of Prescription Drug Products.

13. Medications used for cosmetic purposes.

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

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

16. Prescription Drug Products when prescribed to treat infertility.

17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.

18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.

19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

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

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

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

23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

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

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

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

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

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

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

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.

6. Corrective shoes, unless an integral part of a leg brace.

7. Shoe inserts (unless custom made).

8. Arch supports.

G. Medical Supplies

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

   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
    - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
    - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

J. 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 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.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.

11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

12. Surgical and non-surgical treatment of obesity.

13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

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

15. In vitro fertilization regardless of the reason for treatment.

M. 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 residence.

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

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

   This exclusion does not apply to mammography.

N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

4. The reversal of voluntary sterilization.

5. Fetal reduction surgery.

6. Abortion, except for Therapeutic Abortion.

O. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

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

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

3. Health services while on active military duty.

P. 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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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

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

4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.

5. Gambling disorders.

6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Q. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

R. Travel

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

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

S. Types of Care

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

T. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

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

U. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - ♦ Medically Necessary.

- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

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

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

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

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

When to Enroll and When Coverage Begins

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

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Subject to a determination of the Indiana Health Insurance Exchange, a newborn child of the Policyholder or the Policyholder's spouse will be covered from the time of birth until the 31st day after birth. Coverage will terminate on the 31st day following birth, unless we have received notice of the child's birth and any additional premium required. Coverage of the newborn child shall include coverage of Sickness and Injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including intpatient and outpatient expenses arising from medical and dental treatment involved in the management of cleft lip and cleft palate.

Subject to a determination of the Indiana Health Insurance Exchange, a child placed for adoption with the Policyholder or the Policyholder's spouse will be covered from the date of Placement until the 31st day following Placement unless the Placement is disrupted prior to legal adoption and the child is removed from the insured's custody. Coverage will terminate on the 31st day following Placement, unless we have received notice of the intent to adopt the child and any additional premium required.

"Placement" when used in reference to an adoption, means the earlier of:

- The date of placement for the purpose of adoption.
- The date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you or a third party identified above.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

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

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

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

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

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

- **Failure to Pay**

  You fail to pay the required Premium.

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

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

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

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

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

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

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

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

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

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

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

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

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

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

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Time Limit on Certain Defenses

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent mistatements, made in the application for coverage shall be used to void the Policy or deny a claim for loss incurred after the expiration of this two year period.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

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

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

Section 6: Questions, Complaints and Appeals

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

Filing a Grievance

A grievance is any dissatisfaction expressed by, or on your behalf, regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Investigational Service
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between you and us; or
- Our decision to rescind the Policy

And for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

A grievance may be submitted orally or in writing. You or a person acting on your behalf may file a grievance.

The written request may be sent directly to us at the following address:

All Savers Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]

We will conduct a full and fair review of your grievance. The review of your grievance will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

We will acknowledge our receipt of your grievance, either orally or in writing, within 5 business days after receipt of the grievance. Grievances regarding appropriateness, medical necessity, or Experimental or Investigational Services will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination. All other grievances will be reviewed by at least one individual who:

- Was not involved in the making the original determination;
- Is not the subordinate of the original reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the grievance.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the grievance.

Grievance Determinations

For procedures associated with urgent requests for benefits, see Urgent Grievances that Require Immediate Action below.

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

- For services not yet received:

- The grievance review will be resolved as quickly as possible but not more than 15 calendar days from receipt of a grievance of a denied request for benefits. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 15 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

- For all other grievances:
  - The grievance review will be resolved as quickly as possible, but not more than 20 business days after receiving all information reasonably necessary to complete the review. If we are unable to make a decision regarding the grievance within the 20 day period due to circumstances beyond our control, we will notify in writing before the 20th business day. We will then issue a written decision within a total of 30 calendar days after receipt of the grievance, regardless of whether all information has been received. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

Urgent Grievances that Require Immediate Action

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

- The grievance does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your grievance.

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

Internal Appeals Review

If you are not satisfied with the grievance decision, you have the right to appeal, orally or in writing, within 60 calendar days from your receipt of our grievance decision.

We will acknowledge our receipt of your appeal, either orally or in writing, within 5 business days after receipt of the appeal. If your appeal involves appropriateness, medical necessity, or experimental or investigational treatment, we will appoint a panel of one or more qualified individuals to resolve the appeal. The panel will include one or more individuals who:

- Have knowledge of the medical condition, procedure, or treatment at issue;
- Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
- Were not involved in the initial determination or the grievance review; and
- Do not have a direct business relationship with you or your provider who previously recommended the health care procedure, treatment, or service giving rise to the appeal.

You have the right to appear in person before the panel to present your case. If you are unable to appear in person, you have the right to otherwise appropriately communicate with the panel.

All other appeals of grievances that are based in whole or in part on a medical judgment will be reviewed in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination or the grievance review.
If the appeal concerns a rescission, a panel of individuals who were not involved in the original determination and who are not subordinates of the original reviewer will review the appeal.

All other appeals will be reviewed by an impartial person who:

- Was not involved in the making the original determination or the grievance review;
- Is not the subordinate of the original reviewer or the grievance reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the appeal.

The review of your appeal will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the appeal.

Appeal Determinations

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

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

- For services not yet received:
  - An appeal of a grievance decision will be resolved as quickly as possible but not more than 15 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of5 business days after the investigation is complete or 15 calendar days after the appeal is received.
- For all other grievances :
  - An appeal of a grievance decision will be resolved as quickly as possible, but not more than 30 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the appeal is received.

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

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

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your appeal.

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

External Review

If, after exhausting our internal review process, you are not satisfied with the decision made by us, you may be entitled to request an external review. You may request an external review of a grievance or appeal regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Iinvestigational Service; or
- Our decision to rescind your Policy.

An external review may be requested within 120 days after receipt of our appeal decision. You may request a standard external review by sending a written request to the address set out in the decision letter. If the grievance or appeal is related to an illness, disease, condition, injury, or a disability for which the time frame for a standard review would seriously jeopardize your life or health or you ability to reach and maintain maximum function, an expedited review will be allowed. An expedited external review may be requested by calling the toll-free number on your ID card or by sending a written request to the address set out in the decision letter.

We are responsible for selecting an IRO from the list of IROs that are certified by the State of Indiana Department of Insurance. A different IRO must be selected for each external review and we will not repeat a selection until all IROs have been used.

Reconsideration during the External Review Process

If, at any time during the external review process, you submit information to us that was not previously submitted for review, we have the right to reconsider our decision. At such time additional information is received and we wish to reconsider our decision, we shall notify the IRO and the external review will cease.

We will have 15 days to review the additional information and reconsider our decision. In the case of an expedited review, we will make a decision within 72 hours. We will notify you of our decision.

If we determine to uphold our original decision, you may request that the IRO resume the external review.

If we choose not to reconsider the additional information submitted, we will forward the information to the IRO within 2 business days of receipt of the information.

External Review Decision

In the case of a non-expedited review, the IRO's decision is to be made within 15 business days after the request is filed. The IRO is to notify us and you of the decision within 72 hours after making the decision.

An expedited review must be completed within 72 hours after all information is submitted to the IRO. The IRO is to notify us and you of the decision within 24 hours after making the decision.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

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

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

Your Relationship with Providers

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

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of

providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

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

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

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes,

including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

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

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.

- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

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

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

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

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

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

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

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

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

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

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

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

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

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

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

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

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

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

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

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

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

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

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

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

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

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

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

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

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

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

- ♦ Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

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

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

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

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

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

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

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

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

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

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

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

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

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

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

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

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

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

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

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

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

Please note:

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

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

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

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

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Gold Choice 1250, Gold Choice 1250-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$1,250 per Covered Person, not to exceed $2,500 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Private Duty Nursing visits provided in a home setting are limited to 82 visits per year to a maximum of 164 visits per lifetime.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			

Payment Term And Description		Amounts	
Lab Testing - Outpatient:	90%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	90%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-**	90%	Yes	Yes

Payment Term And Description		Amounts	
Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services -*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $30 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Outpatient Therapy.			
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No ***No***	No No No
17. Prosthetic Devices			
	90%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	90%	Yes	Yes

Payment Term And Description		Amounts	
• 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	90%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	90%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.

Payment Term And Description		Amounts	
24. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Coverage for Dental			
	90%	Yes	Yes
28. Autism Spectrum Disorders			
	90%	Yes	Yes
29. Cancer Chemotherapy			
	90%	Yes	Yes

Payment Term And Description		Amounts	
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%
Space Maintainers (Spacers)	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	90%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice HSA 2600, Silver Choice HSA 2600-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$2,600 per Covered Person, not to exceed $5,200 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,450 per Covered Person, not to exceed $12,900 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense**	100%	Yes	Yes

Payment Term And Description		Amounts	
for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes

Payment Term And Description		Amounts	
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes

Payment Term And Description	Amounts		
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
24. Surgery - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 1900

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.	$1,900 per Covered Person, not to exceed $3,800 for all Covered Persons

Payment Term And Description	Amounts
Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
• Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	

Copayment

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

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

- The applicable Copayment.
- The Eligible Expense.

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

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

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

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**

Payment Term And Description		Amounts	
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**]	100%	Yes	Yes

Payment Term And Description	Amounts		
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
15. Physician's Office Services -			

Payment Term And Description		Amounts	
Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes

Payment Term And Description	Amounts		
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
24. Surgery - Outpatient			
	100%	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes

Payment Term And Description	Amounts		
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.

- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 550

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$550 per Covered Person, not to exceed $1,100 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network**	100%	Yes	Yes

Payment Term And Description		Amounts	
provider and the amount we determine to be an Eligible Expense for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes

Payment Term And Description		Amounts	
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			

Payment Term And Description	Amounts		
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient	100%	Yes	Yes

Payment Term And Description		Amounts	
rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
24. Surgery - Outpatient			
	100%	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes

Payment Term And Description	Amounts		
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.

- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	100%
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to 1 time per 60 months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 75

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$75 per Covered Person, not to exceed $150 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	Yes	Yes

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes

Payment Term And Description	Amounts		
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*	100%	Yes	Yes

Payment Term And Description	Amounts		
• Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy.	100%	Yes	Yes

Payment Term And Description	Amounts		
• 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	100%	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthetic/Hospital Charges for Dental Care			
	100%	Yes	Yes

Payment Term And Description	Amounts		
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible

Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 3500, Silver Choice 3500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	80%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length		

Payment Term And Description	Amounts		
	of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	80%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	80%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a			

Payment Term And Description	Amounts		
pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
28. Autism Spectrum Disorders			
	80%	Yes	Yes
29. Cancer Chemotherapy			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes

Payment Term And Description		Amounts	
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	80%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures,	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 5000, Silver Choice 5000-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	80%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	80%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	80%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	80%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.

Payment Term And Description	Amounts		
24. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthetic/Hospital Charges for Dental Care			
	80%	Yes	Yes
28. Autism Spectrum Disorders			
	80%	Yes	Yes
29. Cancer Chemotherapy			
	80%	Yes	Yes

Payment Term And Description	Amounts		
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

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

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	80%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures,	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 2000, Silver Choice 2000-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$2,000 per Covered Person, not to exceed $4,000 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network**	70%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.

Payment Term And Description		Amounts	
provider and the amount we determine to be an Eligible Expense for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
X-Ray and Other Diagnostic Testing - Outpatient:	70% 70%	Yes Yes	Yes Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes

Payment Term And Description	Amounts		
11. Mental Health Services			
	Inpatient 70%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $30 per visit	Yes	No
12. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	70%	Yes	Yes
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist	Yes	No

Payment Term And Description		Amounts	
diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $60 per visit for services provided by any other Physician		
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No

Payment Term And Description		Amounts	
Breast pumps	100%	***No***	No
17. Prosthetic Devices			
	70%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	70%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes

Payment Term And Description	Amounts		
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
•	*Inpatient* 70%	Yes	Yes
•	*Outpatient* 100% after you pay a Copayment of $30 per visit	Yes	No
23. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered		

Payment Term And Description		Amounts	
do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
28. Autism Spectrum Disorders			
	70%	Yes	Yes
29. Cancer Chemotherapy			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes

Payment Term And Description	Amounts		
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale

currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based	

Payment Term And Description	Amounts
on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%
Space Maintainers (Spacers)	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	70%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 2500

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$2,500 per Covered Person, not to exceed $5,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description	Amounts		
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	80%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length		

Payment Term And Description	Amounts		
	of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	80%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	80%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a			

Payment Term And Description	Amounts		
pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
28. Autism Spectrum Disorders			
	80%	Yes	Yes
29. Cancer Chemotherapy			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	80%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures,	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 3500-2

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	80%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	80%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation) •	80%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	80%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes

Payment Term And Description	Amounts		
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthetic/Hospital Charges for Dental Care			
	80%	Yes	Yes
28. Autism Spectrum Disorders			
	80%	Yes	Yes
29. Cancer Chemotherapy			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $750 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug	

Payment Term And Description	Amounts
Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	80%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures,	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 1200

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$1,200 per Covered Person, not to exceed $2,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	70%	Yes	Yes, after the Per Occurence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70%	Yes	Yes

Payment Term And Description	Amounts		
X-Ray and Other Diagnostic Testing - Outpatient:	70%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	70%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	70%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	70%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes
20. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes

Payment Term And Description	Amounts		
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
28. Autism Spectrum Disorders			
	70%	Yes	Yes
29. Cancer Chemotherapy			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	70%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	70%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures,	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 250, Silver Choice 250-1, Silver Choice 250-2]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$250 per Covered Person, not to exceed $500 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $150 per visit is satisfied
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	90%	Yes	Yes

Payment Term And Description	Amounts		
X-Ray and Other Diagnostic Testing - Outpatient:	90%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	90%	Yes	Yes
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the	100% after you pay a Copayment of $10 per	Yes	No

Payment Term And Description		Amounts	
Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $30 per visit for services provided by any other Physician		
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		

Payment Term And Description		Amounts	
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100 100%	No No No	No No No
17. Prosthetic Devices			
	90%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	90%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes

Payment Term And Description	Amounts		
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	90%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization			

Payment Term And Description	Amounts		
and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	90%	Yes	Yes
28. Autism Spectrum Disorders			
	90%	Yes	Yes
29. Cancer Chemotherapy			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $250 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	90%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	90%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures,	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 100, Silver Choice 100-1, Silver Choice 100-2]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$100 per Covered Person, not to exceed $200 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$550 per Covered Person, not to exceed $1,100 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$150 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
X-Ray and Other Diagnostic Testing - Outpatient:	90% 90%	Yes Yes	Yes Yes

Payment Term And Description	Amounts		
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	90%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $20 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	90%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	90%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	90%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $200 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization			

Payment Term And Description	Amounts		
and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	90%	Yes	Yes
28. Autism Spectrum Disorders			
	90%	Yes	Yes
29. Cancer Chemotherapy			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $100 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%
Space Maintainers (Spacers)	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	90%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Bronze Choice HSA 4900, Bronze Choice HSA 4900-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$4,900 per Covered Person, not to exceed $9,800 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,450 per Covered Person, not to exceed $12,900 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	Yes	Yes

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length		

Payment Term And Description	Amounts		
	of stay.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	100%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	100%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
23. Surgery - Outpatient			
	100%	Yes	Yes
24. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			

Payment Term And Description		Amounts	
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Coverage for Dental			
	100%	Yes	Yes
28. Autism Spectrum Disorders			
	100%	Yes	Yes
29. Cancer Chemotherapy			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes

Payment Term And Description	Amounts		
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is

usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months .	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery ***(Subject to payment of the Annual Deductible.)***	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Bronze Choice 5500, Bronze Choice 5500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$5,500 per Covered Person, not to exceed $11,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	70%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	70%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $35 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
•	*Inpatient* 70% *Outpatient* 100% after you pay a Copayment of $35 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	70%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.*	100% after you pay a Copayment of $35 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $75 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	***No***	No
18. Prosthetic Devices			
	70%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy.	70%	Yes	Yes

Payment Term And Description	Amounts		
• 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	70%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
•	*Inpatient* 70%	Yes	Yes
•	*Outpatient* 100% after you pay a Copayment of $35 per visit	Yes	No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $500 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes

Payment Term And Description	Amounts		
29. Autism Spectrum Disorders			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible

Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at

[www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network

facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	70%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	70%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures,	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Gold Choice $0, Silver Choice $0, Bronze Choice $0, Silver Choice HSA $0, Bronze Choice HSA $0]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

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

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

Care Management

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	No Annual Deductible
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$0 per Covered Person
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of:	

Payment Term And Description	Amounts
• The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	No	No
	Air or Water Ambulance: 100%	No	No
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	No	No
	Air or Water Ambulance: 100%	No	No

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and *Outpatient Prescription Drugs.* Benefits for diabetes supplies will be the same as those stated under *Outpatient Prescription Drugs*.		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	No	No
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	No	No

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	No	No
7. Hospice Care			
	100%	No	No
8. Hospital - Inpatient Stay			
	100%	No	No
9. Lab, X-Ray and Diagnostics - Outpatient			

Payment Term And Description		Amounts	
Lab Testing - Outpatient:	100%	No	No
X-Ray and Other Diagnostic Testing - Outpatient:	100%	No	No
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	No	No
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	No No	No No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	No No	No No
13. Pharmaceutical Products - Outpatient			
	100%	No	No
14. Physician Fees for Surgical and Medical Services			

Payment Term And Description		Amounts	
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	No	No
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.*	100%	No	No

Payment Term And Description	Amounts		
• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	No	No
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy.	100%	No	No

Payment Term And Description	Amounts		
• 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	No	No
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	No	No
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	No No	No No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	100%	No	No
25. Therapeutic Treatments - Outpatient			
	100%	No	No
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	No	No
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	No	No

Payment Term And Description	Amounts		
29. Autism Spectrum Disorders			
	100%	No	No
30. Dental Services - Accident Only			
	100%	No	No
31. Inherited Metabolic Disease			
	100%	No	No
32. Orthotic Devices			
	100%	No	No
33. Ostomy Supplies			
	100%	No	No
34. TMJ			
	100%	No	No
35. Vision Correction Following Injury/Surgery			
	100%	No	No
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	No	No

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible

Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at

[www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

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

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network

facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

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

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

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

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

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	No Copayment

Pediatric Dental Services Schedule of Benefits

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

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		100% of billed charges

Member Enrollment Form

Indiana

UnitedHealthcare
Underwritten by
All Savers Insurance Company

To complete the enrollment process, please be thorough and fill out all sections.

Requested Effective Date of Coverage / Date of Change _____/_____/_____	Policy Number (if known)

Reason for Application
□ New Plan □ Life Event / Date ____/____/_____ □ Status Change ____/____/____ □ Dependent Add / Delete
□ Change Name / Address □ Annual Open Enrollment □ Other _____

A. Member Information

Last Name	First Name	MI	Social Security Number

Address	Apt#	City	State	Zip Code	Home/Cell Phone

Date of Birth / /	Gender □ M □ F	Email Address	Work Phone

Marital Status □ Single □ Married □ Divorced □ Widowed	Do you use tobacco?[1] □ Yes □ No
Language Preference, if not English	If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No
Primary Care Physician[2] Existing Patient? □ Yes □ No	**Primary Care Dentist**[3]
Physician First & Last Name _____	Dentist First & Last Name _____
Address _____	Provider NPI# ____|____|____|____|____|____|____|____|____|____|
Provider NPI# ____|____|____|____|____|____|____|____|____|____|	Existing Patient? □ Yes □ No

B. Family Information

List all enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Gender □ M □ F	Date of Birth

Spouse [/Domestic Partner]	Social Security Number	Do you use tobacco?[1] □ Yes □ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No

Primary Care Physician[2] Existing Patient? □ Yes □ No	**Primary Care Dentist**[3]
Physician First & Last Name _____	Dentist First & Last Name _____
Address _____	Provider NPI# ____|____|____|____|____|____|____|____|____|____|
Provider NPI# ____|____|____|____|____|____|____|____|____|____|	Existing Patient? □ Yes □ No

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see UnitedHealthcare representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible member, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon the member for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by All Savers Insurance Company

Member Name _____

B. Family Information (continued)

Relationship[4]	Last Name	First Name	MI	Gender □ M □ F	Date of Birth
Dependent	Social Security Number	Do you use tobacco?[1] □ Yes □ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No			

Primary Care Physician[2] Existing Patient? □ Yes □ No

Physician First & Last Name _____

Address _____

Provider NPI# ____|____|____|____|____|____|____|____|____|____|

Primary Care Dentist[3] Existing Patient? □ Yes □ No

Dentist First & Last Name _____

Provider NPI# ____|____|____|____|____|____|____|____|____|____|

Permanently disabled and age 26 or older[5] □ Yes □ No

Relationship[4]	Last Name	First Name	MI	Gender □ M □ F	Date of Birth
Dependent	Social Security Number	Do you use tobacco?[1] □ Yes □ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No			

Primary Care Physician[2] Existing Patient? □ Yes □ No

Physician First & Last Name _____

Address _____

Provider NPI# ____|____|____|____|____|____|____|____|____|____|

Primary Care Dentist[3] Existing Patient? □ Yes □ No

Dentist First & Last Name _____

Provider NPI# ____|____|____|____|____|____|____|____|____|____|

Permanently disabled and age 26 or older[5] □ Yes □ No

Relationship[4]	Last Name	First Name	MI	Gender □ M □ F	Date of Birth
Dependent	Social Security Number	Do you use tobacco?[1] □ Yes □ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No			

Primary Care Physician[2] Existing Patient? □ Yes □ No

Physician First & Last Name _____

Address _____

Provider NPI# ____|____|____|____|____|____|____|____|____|____|

Primary Care Dentist[3] Existing Patient? □ Yes □ No

Dentist First & Last Name _____

Provider NPI# ____|____|____|____|____|____|____|____|____|____|

Permanently disabled and age 26 or older[5] □ Yes □ No

Relationship[4]	Last Name	First Name	MI	Gender □ M □ F	Date of Birth
Dependent	Social Security Number	Do you use tobacco?[1] □ Yes □ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? □ Yes □ No			

Primary Care Physician[2] Existing Patient? □ Yes □ No

Physician First & Last Name _____

Address _____

Provider NPI# ____|____|____|____|____|____|____|____|____|____|

Primary Care Dentist[3] Existing Patient? □ Yes □ No

Dentist First & Last Name _____

Provider NPI# ____|____|____|____|____|____|____|____|____|____|

Permanently disabled and age 26 or older[5] □ Yes □ No

C. Product Selection

Please write the medical plan being purchased. Attach your health insurance quote.

[Medical Plan Name _____]

Member Name _____

D. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
□ No □ Yes (if yes, please complete this section.)

Prior medical carrier name	Effective date	End date
_____	___/___/___	___/___/___

Prior coverage type: □ Member □ Spouse □ Child(ren) □ Family

E. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? □ Yes (continue completing this section) □ No (skip the rest of this section)

Name of other carrier _____

Other Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Member:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Member Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

□ Enrolled in Part A: Effective Date _____ □ Ineligible for Part A* □ Not Enrolled in Part A (chose not to enroll)**
□ Enrolled in Part B: Effective Date _____ □ Ineligible for Part B* □ Not Enrolled in Part B (chose not to enroll)**
□ Enrolled in Part D: Effective Date _____ □ Ineligible for Part D* □ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: □ Over 65 □ Kidney Disease □ Disabled □ Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)? □ Yes □ No Start Date ____/____/_____

Medicare – Spouse / Dependent Name:_____

□ Enrolled in Part A: Effective Date _____ □ Ineligible for Part A* □ Not Enrolled in Part A (chose not to enroll)**
□ Enrolled in Part B: Effective Date _____ □ Ineligible for Part B* □ Not Enrolled in Part B (chose not to enroll)**
□ Enrolled in Part D: Effective Date _____ □ Ineligible for Part D* □ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: □ Over 65 □ Kidney Disease □ Disabled □ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.
** 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 A, Part B, and/or Part D as applicable.

F. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: □ White □ Black, African-American □ American Indian/Alaska Native □ Asian
□ Native Hawaiian/Pacific Islander □ Other Race, please specify_____

2. Are you of Hispanic or Latino origin? □ Yes □ No

G. Signature

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated medical coverage. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Member Signature for all applying	Spouse Signature (if applying for coverage)

H. Broker Statement

Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Information Practices [and a Conditional Receipt or Conditions Prior to Coverage].

Signature of Licensed Broker	Print Full Name
Broker Number |___|___|___|___|___|___|___|___|___|___|	Broker Email Address

When completed or for additional information
Contact us at UnitedHealthcare
Online www.unitedhealthone.com or
Call Direct Sales (800) 444-8990
Printed applications may be faxed to the following: **(801) 478-5460**

UnitedHealthcare Address:
7440 Woodland Dr.
Indianapolis, IN 46278

Individual Off-Exchange Qualified Health Plan Policy Amendment

All Savers Insurance Company

As described in this Amendment, the Qualified Health Plan Policy is modified to support coverage for Eligible Persons who wish to purchase the same Qualified Health Plan coverage off the individual exchange.

1. *Section 3: When Coverage Begins and Premiums* is replaced in its entirety with the following:

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete and submit an application for insurance and make the required Premium payment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

Who is eligible to enroll and who qualifies as a Dependent will be determined by us under the terms of this Policy.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules for coverage under this Policy and as determined based on information submitted in the application for coverage. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

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

When to Enroll and When Coverage Begins

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

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can apply for insurance for themselves and their Dependents, as determined by state or federal law.

Coverage begins on the date identified in this Policy if we receive the completed application and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by state or federal law.

Adding New Dependents

Policyholders may apply for insurance for Dependents only as described below.

The Policyholder must notify us of a new Dependent to be added to this Policy. Additional Premium may also be required, and it will be calculated from the date coverage is effective.

Dependent Eligibility

Your Dependents become eligible for insurance on the later of following:

- The date you became insured under this Policy.
- The first day of the first full calendar month after the date of becoming your Dependent.

Effective Date for Initial Dependents:

The effective date for your initial Dependents, if any, is shown on the face page of the Policy. Only Dependents included in the application for insurance will be covered on your effective date.

Adding a Newborn Child:

A Dependent child born to you or your spouse will be covered from the time of birth until the 31st day after birth, unless you or your spouse advises us not to add the newborn child.

Adding an Adopted Child:

A Dependent child legally placed for adoption with you or your spouse will be covered from the date of placement until the 31st day after placement, unless the placement is disrupted prior to legal adoption and the child is removed from your or your spouse's custody.

As used in this provision, "placement" means the earlier of the following:

- The date that you or your spouse assume physical custody of the child for the purpose of adoption.
- The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.

Additional Premium:

Additional Premium may be required to continue coverage beyond the 31st day following the birth or placement of the child. The required Premium will be calculated from the date of birth or date of placement for adoption. Coverage of the child will terminate on the 31st day following birth or placement,

unless we have received both written notice of the child's birth or your or your spouse's intent to adopt the child and the required premium within 90 days of the date of birth or date of placement.

Adding Other Dependents:

If you submit an application for insurance on a Dependent and you pay the required Premiums, then the effective date will be shown in the written notice to you that the Dependent is insured.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above.

When adding a Dependent, Premiums shall be pro-rated based upon the effective date of the Dependent's coverage.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify us of your new residence. Your Premium will be based on your new residence beginning on the date determined by us. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

2. *Section 4: When Coverage Ends* is replaced in its entirety with the following:

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

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

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

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

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date we terminate as a Qualified Health Plan Issuer.
  - The date this benefit plan is decertified as a *Qualified Health Plan*.
  - The date we specify that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.

- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date you request if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

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

- **Failure to Pay**

  You fail to pay the required Premium.

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

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

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

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

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

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

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

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy.

3. The definition of Eligible Person in *Section 8: Defined Terms* is replaced with the following:

Eligible Person - a person who meets the eligibility requirements for coverage under this Policy and as determined based on information submitted in the application. An Eligible Person must live within the Service Area.

_____

(Name and Title)

SERFF Tracking #:	*UHLC-129514067*	***State Tracking #:***	*IEXPOL.I.15.IN*	***Company Tracking #:***	*IEXPOL.I.15.IN*

State:	*Indiana*	***Filing Company:***	*All Savers Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Individual Health*		
Project Name/Number:	*IEXPOL.I.15.IN/IEXPOL.I.15.IN*		

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	%
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	N/A

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
All Savers Insurance Company	New Product	%	%				%	%

State: *Indiana* ***Filing Company:*** *All Savers Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Individual Health*
Project Name/Number: *IEXPOL.I.15.IN/IEXPOL.I.15.IN*

Rate Review Detail

COMPANY:

Company Name: All Savers Insurance Company
HHS Issuer Id: 36373

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
2015 Indiana On-Exchange Product	36373IN002	36373-169033	59219

Trend Factors: Plan, age, tobacco-usage status and area factors are used. Factors and rating formula are detailed in the included Rate Manual.

FORMS:

New Policy Forms: IEXPOL.I.15.IN, et.al.
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 59,219
Benefit Change: None
Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium: 0.00
Total Incurred Claims: 0.00
Annual $: Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium: 25,024,570.00
Projected Incurred Claims: 21,193,447.00
Annual $: Min: 119.26 Max: 1,299.96 Avg: 422.58

SERFF Tracking #:	*UHLC-129514067*	***State Tracking #:***	*IEXPOL.I.15.IN*	***Company Tracking #:***	*IEXPOL.I.15.IN*

State:	*Indiana*	***Filing Company:***	*All Savers Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Individual Health*		
Project Name/Number:	*IEXPOL.I.15.IN/IEXPOL.I.15.IN*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		IN 2015 IEX Rate Manual	IEXPOL.I.15.IN, et.al.	New		IN IEX 2015 Ratebook2.pdf,

All Savers Insurance Company

Form Numbers:
IEXPOL.I.15.IN, et.al.

Rate Pages for State of Indiana Form Filing

For Policies Effective January 1, 2015 and Later

All Savers Insurance Company

PREMIUM CALCULATIONS

Calculated Medical Premium

For each person:
Medical Premium (monthly) = RDC of

Base Rate
x Plan Factor
x Age Factor
x Tobacco Factor (if applicable)
x Area Factor

RDC = Round to 2 decimals

Sum the Medical Premium for all persons to be covered. This Subtotal is the Total Monthly Premium.
Note: Only the 3 oldest dependent children under the age of 21 will be included in the premium calculation.

Total Quarterly Premium = Total Monthly Premium * 3

Notes
There is an administrative fee for processing checks returned for non-sufficient funds.
This will only be imposed after the insured has received written notice of the fee.

All Savers Insurance Company

Monthly Base Rate	$384.03

Designation	Deductible	Coinsurance	AV Calculated	Metal/Cat	Plan Factor
Gold Compass 1250	$1,250	90%	79.4%	Gold	1.1370
Silver Compass 2000	$2,000	70%	69.5%	Silver	1.0280
Silver Compass 3500-1	$3,500	80%	70.4%	Silver	1.0380
Silver Compass 5000	$5,000	80%	69.9%	Silver	1.0390
Bronze Compass 5500	$5,500	70%	61.0%	Bronze	0.9400
Silver Compass HSA 2600	$2,600	100%	68.1%	Silver	1.0000
Bronze Compass HSA 4900	$4,900	100%	58.3%	Bronze	0.8520

All Savers Insurance Company

Age	Age Factor	Tobacco Factor
<=20	0.635	1.00
21	1.000	1.05
22	1.000	1.05
23	1.000	1.05
24	1.000	1.05
25	1.004	1.05
26	1.024	1.05
27	1.048	1.05
28	1.087	1.05
29	1.119	1.05
30	1.135	1.05
31	1.159	1.05
32	1.183	1.05
33	1.198	1.05
34	1.214	1.05
35	1.222	1.10
36	1.230	1.10
37	1.238	1.10
38	1.246	1.10
39	1.262	1.10
40	1.278	1.10
41	1.302	1.10
42	1.325	1.10
43	1.357	1.10
44	1.397	1.10
45	1.444	1.10
46	1.500	1.10
47	1.563	1.10
48	1.635	1.10
49	1.706	1.10
50	1.786	1.20
51	1.865	1.20
52	1.952	1.20
53	2.040	1.20
54	2.135	1.20
55	2.230	1.20
56	2.333	1.20
57	2.437	1.20
58	2.548	1.20
59	2.603	1.20
60	2.714	1.20
61	2.810	1.20
62	2.873	1.20
63	2.952	1.20
64+	3.000	1.20

All Savers Insurance Company

State	Rating Area	County	Area Factor
IN	Rating Area 1	Lake LaPorte Porter	0.778
IN	Rating Area 2	Elkhart Kosciusko Marshall St. Joseph Starke	0.704
IN	Rating Area 3	Adams DeKalb Huntington Lagrange Noble Steuben Wabash Wells Whitley	0.690
IN	Rating Area 4	Allen	0.690
IN	Rating Area 5	Benton Jasper Newton Warren White	0.710
IN	Rating Area 6	Cass Fulton Howard Miami Pulaski	0.724
IN	Rating Area 7	Carroll Clinton Fountain Montgomery Putnam Tippecanoe Tipton	0.723
IN	Rating Area 8	Blackford Delaware Grant Jay Randolph	0.745
IN	Rating Area 9	Clay Parke Sullivan Vermillion Vigo	0.786

All Savers Insurance Company

State	Rating Area	County	Area Factor
IN	Rating Area 10	Boone Hamilton Hendricks Marion Morgan Shelby	0.786
IN	Rating Area 11	Fayette Hancock Henry Madison Union Wayne	0.760
IN	Rating Area 12	Bartholomew Decatur Jackson Jennings Rush	0.689
IN	Rating Area 13	Brown Johnson Lawrence Monroe Owen	0.717
IN	Rating Area 14	Dearborn Franklin Ohio Ripley Switzerland	0.787
IN	Rating Area 15	Daviess Dubois Greene Knox Martin Orange Perry Pike Spencer	0.670
IN	Rating Area 16	Clark Crawford Floyd Harrison Jefferson Scott Washington	0.574
IN	Rating Area 17	Gibson Posey Vanderburgh Warrick	0.731

Supporting Document Schedules

Bypassed - Item:	10 Individual Checklist (Accident & Health)
Bypass Reason:	Does not apply.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	10(A) Individual Checklist (Accident & Health)
Comments:	
Attachment(s):	10A_Individual_Checklist.pdf
Item Status:	
Status Date:	

Bypassed - Item:	20(C) Out of State Association/Trust Products Checklist (Accident & Health)
Bypass Reason:	Does not apply.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	4.1 Individual New Rate/Form Requirements (Accident & Health)
Comments:	See Implementation Date Requested on the General Information tab.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0 Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	Does not apply. This is an initial filing for a new Product to be effective for calendar year 2015.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	4.1(A) QHP Individual New Rate/Form Requirements (Accident & Health)
Comments:	See Implementation Date Requested on the General Information tab. The Rate Review Detail information is populated on the Rate / Rule Schedule tab. The Actuarial Memorandum is attached under this requirement on the Supporting Documentation tab. The Unified Rate Review Template is attached on the Supporting Documentation tab.
Attachment(s):	1 - IN IEX State Act Memo.pdf

Item Status:	
Status Date:	

Bypassed - Item:	7.0(A) QHP Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	Does not apply. This is an initial filing for a new Product to be effective for calendar year 2015.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	4.1(B) EHB Individual New Rate/Form Requirements (Accident & Health)
Comments:	See Implementation Date Requested on the General Information tab.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0(B) EHB Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	Does not apply. This is an initial filing for a new Product to be effective for calendar year 2015.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	04 Major Medical Experience Workbook (Accident & Health)
Bypass Reason:	This is an initial filing for a new Product to be effective for calendar year 2015. No experience exists for this Product.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	09 SERFF Data Field Guide (Accident & Health)
Comments:	Acknowledged.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	03 PPACA Uniform Compliance Summary
Comments:	
Attachment(s):	IN IEX PPACA UCS.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*UHLC-129514067*	***State Tracking #:***	*IEXPOL.I.15.IN*	***Company Tracking #:***	*IEXPOL.I.15.IN*

State:	*Indiana*	***Filing Company:***	*All Savers Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Individual Health*		
Project Name/Number:	*IEXPOL.I.15.IN/IEXPOL.I.15.IN*		

Satisfied - Item:	Complaint Notice
Comments:	
Attachment(s):	IN Complaint Notice 43082.pdf
Item Status:	
Status Date:	

Satisfied - Item:	EHB Crosswalk Tool
Comments:	
Attachment(s):	EHB_Crosswalk_Tool.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	4 - IN URRT Part I - values.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Part III - Federal Actuarial Memorandum
Comments:	
Attachment(s):	12 - IN 2015 IEX Unique Plan Design Justification.pdf 5 - IN IEX Part III Act Memo.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Resubmission: IN IEX Policy-Highlighted
Comments:	
Attachment(s):	IN IEX Policy - Highlighted 5 30 14 Resubmission.pdf
Item Status:	
Status Date:	

Satisfied - Item:	20140611 Company Response
Comments:	
Attachment(s):	20140611 CR.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*UHLC-129514067*	***State Tracking #:***	*IEXPOL.I.15.IN*	***Company Tracking #:***	*IEXPOL.I.15.IN*

State:	*Indiana*	***Filing Company:***	*All Savers Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Individual Health*		
Project Name/Number:	*IEXPOL.I.15.IN/IEXPOL.I.15.IN*		

Satisfied - Item:	Resubmission Letter in Response to June 4, 2014 , 14 item Objection Letter
Comments:	
Attachment(s):	IN IEXPOL Flg Resub Letter 6 19 14.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Red-line documents requested by Kim Isles
Comments:	
Attachment(s):	Redline IN IEX Policy with IN IEX Policy Revised 061014.pdf Redline Amendment-IEX-2015-Off Exchange-IN.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Small Group Attestation
Comments:	
Attachment(s):	IN 2014 UHC SG filing.pdf IN 2014 UHC SG URRT Part III.pdf
Item Status:	
Status Date:	

Satisfied - Item:	20140717 Objection Response
Comments:	
Attachment(s):	IN Justification Form.pdf 20140717 CR 102.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Response to July 15 Objection Letter - Red-Lined Documents
Comments:	
Attachment(s):	IN IEX Policy Revised 072514 Red-lined Version.pdf Amendment-IEX-2015-Off Exchange-IN 072514 Redlined.pdf
Item Status:	
Status Date:	

Satisfied - Item:	July 29, 2014 - Kim Isles requested Redline Version
Comments:	
Attachment(s):	Redlined- IN IJuly 25 2014 Requested Redline version EX Schedule SBN IEX CHC I 15 IN S 1200.pdf
Item Status:	

SERFF Tracking #:	*UHLC-129514067*	***State Tracking #:***	*IEXPOL.I.15.IN*	***Company Tracking #:***	*IEXPOL.I.15.IN*

State:	*Indiana*	***Filing Company:***	*All Savers Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Individual Health*		
Project Name/Number:	*IEXPOL.I.15.IN/IEXPOL.I.15.IN*		

Status Date:	

Satisfied - Item:	AVC Screenshots
Comments:	
Attachment(s):	Bronze Compass 5500.pdf Bronze Compass HSA 4900.pdf Gold Compass 1250.pdf Silver Compass 2000.pdf Silver Compass 3500-1.pdf Silver Compass 5000.pdf Silver Compass HSA 2600.pdf
Item Status:	
Status Date:	

Satisfied - Item:	August 1, 2014 Resubmission - IN IEX Policy Revised073114 Redlined Version
Comments:	
Attachment(s):	IN IEX Policy Revised 073114 Redlined.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*UHLC-129514067*	***State Tracking #:***	*IEXPOL.I.15.IN*	***Company Tracking #:***	*IEXPOL.I.15.IN*

State:	*Indiana*	***Filing Company:***	*All Savers Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Individual Health*		
Project Name/Number:	*IEXPOL.I.15.IN/IEXPOL.I.15.IN*		

Attachment 4 - IN URRT Part I - values.xlsm is not a PDF document and cannot be reproduced here.

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

10(A) Non-Grandfathered
Individual Major Medical & Dental

This checklist must be submitted with any form filings for Individual Major Medical or Individual Dental plans that are not Grandfathered. This checklist should also be used for Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation. This checklist should not be used for HMO plans.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name_____ **NAIC #** _____

Form number(s)_____ **Filing date**_____

Product Type: ☐ **Major Medical** ☐ **Pediatric Stand-Alone Dental**

Exchange Participation: ☐ **Off-Exchange** ☐ **On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

Contents

A. General Filing Requirements **2**
B. Required Provisions **4**
C. Optional Provisions **8**
D. Individual A&H Policies *must provide* **10**
E. General Regulatory Issues **12**
F. Individual A&H Policies *must cover* **14**
G. ACA Must Provide **14**
H. Specific Requirements for Qualified Health Plans **29**
I. Specific Requirements for Exchange Certified Stand-Alone Dental Plan **31**

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.		
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm		
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.		
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.		
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. Pl*ease acknowledge.*		
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.		
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-8-5-3(a)(1)	**ENTIRE CONTRACT: CHANGES**: This policy, including the endorsement and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.		
IC 27-8-5-3(a)(2)	**TIME LIMIT ON CERTAIN DEFENSES**: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant on the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-3(a)(3)	**GRACE PERIOD**: A grace period of "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall remain in force. For On-Exchange (Marketplace) products, see the section of this checklist titled “Specific Requirements for Qualified Health Plans” for grace Period requirements.		
IC 27-8-5-3(a)(4)	**REINSTATEMENT**: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the Insurer or by any agent authorized by the Insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy (see code for remainder of language).		
IC 27-8-5-3(a)(5)	**NOTICE OF CLAIM**: Written notice of claim must be given to the Insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the Insurer, or to any authorized agent of the Insurer, with information sufficient to identify the insured, shall be deemed notice to the Insurer. (See Ind. Code Sec. 27-8-5-3(a)(5) for alternative language for loss-of-time benefit policies.)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-3(a)(6)	**CLAIM FORMS**: The Insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.		
IC 27-8-5-3(a)(7)	**PROOF OF LOSS**: Written proof of loss must be furnished to the Insurer at its office within 90 days after the date of such loss (within 90 days after termination of Insurer's liability period in case of policy providing periodic payments.) Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year after the time proof is otherwise required.		
IC 27-8-5-3(a)(8) IC 27-8-5.7	**TIME OF PAYMENT OF CLAIMS**: Payment for any loss (other than loss for which the policy provides periodic payment) will be paid immediately upon receipt of due written proof of loss, OR an insurer shall pay or deny each clean claim or notify the claimant of any deficiencies within 30 days if the claim is filed electronically or within 45 days if the claim is filed on paper, whichever is more favorable to the policyholder. If a policy provides for a periodic payment, it will not be paid less frequently than monthly. Any balance remaining unpaid upon the termination of liability when the policy provides periodic payment will be paid immediately upon receipt of due written proof.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-3(a)(9)	**PAYMENT OF CLAIMS**: Indemnity for loss of life will be paid in accordance with the beneficiary designation and the provisions respecting such payment that may be prescribed herein and effective at the time of payment. If no designation or provision is then effective, such indemnity will be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the Insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.		
IC 27-8-5-3(a)(10)	**PHYSICAL EXAMINATIONS AND AUTOPSY**: The Insurer at its own expense shall 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 hereunder and to make an autopsy in case of death where it is not forbidden by law.		
IC 27-8-5-3(a)(11)	**LEGAL ACTIONS**: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.		
IC 27-8-5-3(a)(12)	**CHANGE OF BENEFICIARY**: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary, or to any other change in this policy.		
IC 27-8-5-22	**REFUND OF PREMIUM AT DEATH**: Pro-rated from date following date of death to end of paid period.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-28 IC 27-8-29	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.		
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance		
C. Optional Provisions	**The following provisions are not required in an individual policy. However, if a policy issued or delivered in Indiana addresses the matters listed below, its provisions must appear as stated, preceded by the captions or other approved captions. Any variance in this language must be at least as favorable to the insured and MUST be approved by the Department of Insurance.**		
IC 27-8-5-3(b)(2)	**MISSTATEMENT OF AGE**: If the age of the insured has been misstated, the amounts payable shall be such as the premium paid would have purchased at the correct age.		
IC 27-8-5-3(b)(3)	**OTHER INSURANCE WITH THIS INSURER**: If the insured currently has more than one policy with this Insurer, with total benefits exceeding the maximum limit of the policy, then the excess insurance is void and the premium for the excess insurance shall be returned. (Alternatively, only one policy elected by the insured shall be effective, and the Insurer will return any premium for other policies.)		
IC 27-8-5-3(b)(4) IC 27-8-5-3(b)(5)	**INSURANCE WITH OTHER INSURER(S)**: If there is other valid coverage for the same loss, on a provision of service basis or on an expense incurred basis, and this Insurer has not been given notice of the other coverage prior to the loss, the liability of this Insurer will be adjusted as well as a portion of the premiums paid.		
IC 27-8-5-3(b)(7)	**UNPAID PREMIUM**: Any premium due and unpaid upon the payment of a claim under the policy may be deducted from the claim.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-3(b)(8)	**CONFORMITY WITH STATE STATUTES**: Any provision of this policy which, on its effective date, conflicts with the statutes of Indiana (or the state where the insured resides on such date) is hereby amended to conform to the minimum requirements of such statutes.		
IC 27-8-5-3(b)(9)	**ILLEGAL OCCUPATION**: Insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which the contributing cause was the insured's being engaged in an illegal occupation.		
IC 27-8-5-3(b)(10)	**INTOXICANTS AND NARCOTICS**: Insurer shall not be liable for a loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of narcotics unless taken on the advice of a physician. **(Note: to be excluded, the loss must be in consequence of the insured's being intoxicated, not just occurring while the insured is intoxicated or under the influence of narcotics.)** The policy provision under this subdivision may not be used with respect to a policy that provides coverage for hospital, medical, or surgical expenses.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
D. Individual A&H Policies *must provide*			
IC 27-8-5-2(a)(3) IC 27-8-5-28 Bulletin 189	**DEPENDENTS TO AGE 26:** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.		
IC 27-8-5-2(a)(8)	**HANDICAPPED CHILDREN** beyond the age of maturity, (with 31 day notice to company).		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-15.6	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136		
IC 27-8-5-20	**FREE LOOK PERIOD**		
IC 27-8-5-21	**ADOPTED CHILDREN**		
IC 27-8-5-26	**BREAST RECONSTRUCTION & PROSTHESIS** following mastectomy—regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727		
IC 27-8-5.6-2(b)	**NEWBORNS**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-6-4(b)	**REIMBURSEMENT FOR SERVICES**		
IC 27-8-14.5	**DIABETES TREATMENT**, supplies, equipment & education		
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**		
IC 27-8-24-4	**INFANT SCREENING TESTS** required by IC 16-41-17-2 & Minimum maternity stays		
IC 27-8-24.1-5	**INHERITED METABOLIC DISEASE**		
IC 27-8-24.2-5	**ORTHOTIC AND PROSTHETIC DEVICES**		
IC 27-8-24.3	**VICTIMS OF ABUSE** without regard to the abuse		
IC 27-8-26	Individuals without regard to **GENETIC TESTING**		
Bulletin 172	**CHEMOTHERAPY PARITY**		
760 IAC 1-39-7	**AIDS, HIV** and related conditions		
IC 27-8-25	**CLINICAL TRIALS-**Coverage for individuals participating in approved clinical trials: PHSA §2709		
E. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1 and 27-8-5-1.5, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will also be reviewed.**		
IC 27-8-5-1.5(l)(2)	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.		
IC 27-8-5-1.5(l)(2)	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1.5(l)(2)	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be re-filed to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.		
IC 27-8-5-1.5(l)(2)	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.		
IC 27-8-5-1.5(l)(2)	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.		
IC 27-8-5-1.5(l)(2)	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.		
IC 27-8-5-2.5 IC 27-8-5-1.2(l)(2)	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.		
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.		
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
F. Individual A&H Policies *must cover*	**Due to the EHB Benchmark requirements, the following benefits must be covered.**		
IC 27-8-14.2-4 Bulletin 136 Bulletin 179 IC 27-8-5-1(c)	**AUTISM SPECTRUM DISORDER (PREVIOUSLY PDD)** As per Bulletins 136 and 179, "Coverage for services will be provided as prescribed by the insured's treating physician in accordance with a treatment plan." Autism Spectrum Disorders include Asperger's Syndrome and Autism.		
IC 27-13-7-15.3 IC 27-8-5-1(c)	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)		
IC 27-13-7-16 IC 27-8-14.8 IC 27-8-5-1(c)	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk) Due to the EHB Benchmark requirements, prostate cancer screening must be covered		
IC 27-13-7-17 IC 27-8-5-1(c)	**COLORECTAL CANCER SCREENING** Due to the EHB Benchmark requirements, colorectal cancer screening must be covered		
G. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302		
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302		
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302		
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. Combined with Rehabilitation Services PT-20 visits OT-20 visits ST-20 visits ACA §1302		
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130		
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302		
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126		
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please acknowledge* PHSA §2715 75 Fed Reg 41760		
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please acknowledge* PHSA §2728 45 CFR §147.145		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please acknowledge* 45 CFR §156.122(a)		
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please acknowledge* PHSA §2715		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108		
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(e)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125		
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(a)		
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(b)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(b) 45 CFR §155.410		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR § 147.104(b)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.104(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(d)			
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.106(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)		
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.106(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.106(d)		
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)		
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
H. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)		
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)		
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)		
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)		
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330		
I. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.		

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature:_____

Printed Name:_____

Title: _____

Company: _____

Date: _____

INDIANA
Rate Filing Actuarial Memorandum
All Savers Insurance Company
NAIC Number 0707-82406
FEIN: 35-1665915

1. Benefit Structure

a. Scope and Purpose of Filing

Following is a rate filing prepared by All Savers Insurance Company ("the Company"). This filing has been prepared to provide the necessary information required by your insurance department.

The purpose of this filing is to file the initial rates, effective for calendar year 2015, for our Indiana individual On-Exchange product.

This memorandum is intended solely for the information of and use by the Indiana Department of Insurance. It will demonstrate compliance with state and federal laws and regulations and is not intended to be used for any other purpose.

b. Market

This product will be offered in the individual market.

c. Description of Benefits

These are ACA compliant, major medical expense policies sold to individuals and families. Plans cover a percentage of covered expenses in excess of a selected deductible, up to a defined coinsurance limit, and then 100% of covered expenses thereafter. On some plans, certain covered expenses are not subject to the base plan deductible and/or coinsurance but may be subject to a separate deductible and/or copay amounts. Deductibles are on a calendar year basis. There are additional limitations and exclusions for some specific services.

The plans provide coverage for the required essential health benefits. Benefits in excess of essential health benefit requirements include routine foot care for diabetics, which are anticipated to account for 0.05% of claims. There are no state mandated benefits outside the essential health benefits.

2. Proposed Rates

Please see the attached rate book for a complete set of proposed rates. Policyholder premiums are impacted by the following items.

- Age
- Tobacco Use
- Geographic Area
- Plan
- Family Size

3. Projected Experience with Enrollment Projections

Projected experience for the 12 month calendar year rating period of 1/1/2015 – 12/31/2015 is illustrated below.

Calendar Year	Earned Premium	Incurred Claims[1]	Anticipated Loss Ratio	Federal MLR
2015	$25,024,570	$19,741,236	78.9%	87.8%

[1] Incurred Claims include Risk Adjustment and Net Reinsurance Recoveries.

The 87.8% projected loss ratio using the federally prescribed MLR methodology for calendar year 2015 is computed as follows.

Claims	84.7%
Quality Improvements	0.9%
Reinsurance Recoveries	-6.7%
Risk Adjustment Payments	0.0%
Total MLR Claims	**78.9%**
Premium	100.0%
Premium Tax	-1.3%
Income Tax	-2.3%
Reinsurance Fee	-0.9%
Insurer Fees	-2.1%
Exchange Fees	-3.5%
PCORI Fee	-0.0%
Risk Adjustment User Fees	-0.0%
Total MLR Premium	**89.8%**
MLR:	**87.8%**

**Income Tax is calculated as 35% * (Pre-Tax Income + Insurer Fees).*

***Figures may not tally due to rounding of display in the exhibit.*

4. Assumptions

Our starting monthly base rate, as indicated in the rate manual, is $384.03. These rates are intended to be used on a guarantee issue basis, and All Savers Insurance Company does not have relevant historical experience for individual medical guarantee issue products. Therefore, to develop our individual monthly base rate we started with guarantee issue small group data from affiliated carriers and made the appropriate adjustments to reach our final individual base rate. We adjusted the small group January 2014 rate for premium and benefit differentials between our individual product and the small group product using comparable plans. The monthly base rate level, as well as other pricing factors, will continue to be monitored and evaluated with changes proposed in the future as appropriate.

The below assumptions were used in pricing the Indiana On-Exchange product.

1. Estimated Morbidity Differential of the Population Insured

   A key assumption in our manual rate development was the estimated morbidity differential between the individual and small group markets. Our judgment was that historical morbidity differentials for very small size employer groups versus the small group overall average would be an appropriate indicator for this morbidity differential. The chart below shows the historical experience of affiliated small group carriers for the following group sizes: 1-employee, 1-3 employees, and 1-50 employees. While historical morbidity for 1-employee groups could indicate a morbidity load of greater than 100%, we realize that this reflects a level of anti-selection due to the fact that the primary alternative market for these members was the highly underwritten individual market. In the post-2014 guarantee issue environment for the individual market, although we do expect there will still be some anti-selection in the individual market relative to the small group market, we do not anticipate it being quite this high. Additionally, the new products will include more extensive care management.

Therefore, considering the above along with the potential impact of Medicaid spend-down on the individual exchange market in Indiana, we have assumed morbidity for this product of 1.10 times that of a comparable small group product before removing small group adjustments made due to early renewals and small employer market dropout that are not applicable to these individual plans.

Nationwide Experience

Small Group Size	Earned Premium	Incurred Claims	Member Months	Premium PMPM	Claims PMPM	Claims vs 1-50 ees
1ee	45,744,151	58,576,101	87,361	$523.62	$670.51	2.221
1-3ees	410,313,807	379,506,863	855,464	$479.64	$443.63	1.470
1-50ees	6,028,225,051	4,519,101,029	14,970,587	$402.54	$301.87	1.000

Morbidity Load Assumption: 1.10

2. Trend / Emerging Experience
   The manual rates were developed from an affiliated carrier's small group projections for the 2014 calendar year. They were adjusted for trend factors and emerging claims experience.

3. Benefit Differential
   Adjustments were made to the affiliated small group carrier's experience to reflect the benefit variations between the small group portfolio and our individual product. Additional adjustments were made to reflect changes in the preferred drug list.

4. Network Adjustments
   The affiliated carrier's small group projections for the 2014 calendar year include EPO experience. The individual plans included in this filing are EPO plans as well, so no adjustments for network differential were necessary.

5. Demographic Adjustment
   We anticipate our individual exchange business to have a different age/gender composition compared to that of the affiliated small group carrier's business. Therefore, an adjustment was made to the manual rate development to account for the difference in demographic mix.

5. Premium Guarantee Provision

This product does not contain a rate guarantee as policyholders' rates will change each January, regardless of enrollment date.

6. Rating Factors

a. Age Factors

Premiums are adjusted by the HHS approved age factors that vary on an attained age basis.

Age	Age Factors	Age	Age Factors	Age	Age Factors
<=20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64+	3.000

b. Geographic Factors

Premiums are adjusted by Geographic Factors developed by the affiliate carrier.

Rating Area	Area Factor	Rating Area	Area Factor
Rating Area 1	0.827	Rating Area 9	0.786
Rating Area 2	0.704	Rating Area 10	0.786
Rating Area 3	0.690	Rating Area 11	0.760
Rating Area 4	0.690	Rating Area 12	0.689
Rating Area 5	0.710	Rating Area 13	0.717
Rating Area 6	0.724	Rating Area 14	0.787
Rating Area 7	0.723	Rating Area 15	0.670
Rating Area 8	0.745	Rating Area 16	0.574
		Rating Area 17	0.731

c. Tobacco

Premiums are adjusted by tobacco factors that vary by a ratio of 1:1.2 based on the age and tobacco status of the insured.

Age	Tobacco Factor	Age	Tobacco Factor	Age	Tobacco Factor
<=20	1.00	35	1.10	50	1.20
21	1.05	36	1.10	51	1.20
22	1.05	37	1.10	52	1.20
23	1.05	38	1.10	53	1.20
24	1.05	39	1.10	54	1.20
25	1.05	40	1.10	55	1.20
26	1.05	41	1.10	56	1.20
27	1.05	42	1.10	57	1.20
28	1.05	43	1.10	58	1.20
29	1.05	44	1.10	59	1.20
30	1.05	45	1.10	60	1.20
31	1.05	46	1.10	61	1.20
32	1.05	47	1.10	62	1.20
33	1.05	48	1.10	63	1.20
34	1.05	49	1.10	64+	1.20

d. Family Composition

The total premium for family coverage is calculated by summing the premiums for each individual family member. Only the three oldest covered children under age 21 are included for purposes of this calculation.

e. Benefit Plan Factors

The chart below details the AV Pricing Values for all plans included in this product.

Designation	Metal/Cat	Plan Factor
Gold Compass 1250	Gold	1.1370
Silver Compass 2000	Silver	1.0280
Silver Compass 3500-1	Silver	1.0380
Silver Compass 5000	Silver	1.0390
Bronze Compass 5500	Bronze	0.9400
Silver Compass HSA 2600	Silver	1.0000
Bronze Compass HSA 4900	Bronze	0.8520

*f. **Non-Benefit Expenses*** – (all percentages shown are percent of premium)

Our projected non-benefit expenses for the 2015 rating period are shown in the table below.

Premium	100.0%
Claims	-84.7%
Reinsurance Recoveries	6.7%
Risk Adjustment Payments	0.0%
Premium Tax	-1.3%
Reinsurance Fees	-0.9%
Risk Adjustment User Fee	-0.0%
Insurer Fees	-2.1%
Exchange Fees	-3.5%
PCORI Fees	-0.0%
Commissions	-2.5%
Quality Improvements	-0.9%
SG&A	-6.3%
Pre-Tax Income:	**4.5%**
Income Tax *	-2.3%
After-Tax Income:	**2.2%**

**Income Tax is calculated as 35% * (Pre-Tax Income + Insurer Fees).*

***Figures may not tally due to rounding of display in the exhibit.*

g. Impact of Contractual Arrangement

i. Any impact of contractual agreements with health care providers and administrators will be reflected in our trend assumption.

7. <u>Company Financial Position</u>

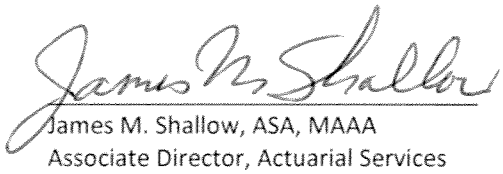
Total Adjusted Capital exceeds 200% of the Authorized Control Level as defined by the NAIC.

8. **Actuarial Certification/Rate Attestation**

I, James M. Shallow, am an Associate Director of Actuarial Services for United Healthcare's Individual Line of Business, which includes All Savers Insurance Company's health insurance products marketed to individuals. I am a member of the American Academy of Actuaries, and I meet the Academy's qualification standards for rendering statements of actuarial opinion, with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment:

- This rate filing is in compliance with the applicable state and federal statutes and regulations.
- This rate filing is in compliance with the applicable actuarial standards of practice (ASOP).
- The same premium rate is being charged without regard to whether the plan is offered through a Marketplace or whether the plan is offered directly from the issuer or through an agent.



6.11.14

James M. Shallow, ASA, MAAA
Associate Director, Actuarial Services

Date

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				☐ Yes ☐ No

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

NOTICE TO INDIANA POLICYHOLDERS AND CERTIFICATEHOLDERS

Questions regarding your policy or coverage should be directed to:

[All Savers Insurance Company
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone: 877-855-6538]

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204

Consumer Hotline: (800) 622-4461 or (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page		of	
Specialist Visit	See Page		of	
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page		of	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page		of	
Outpatient Surgery Physician/Surgical Services	See Page		of	
Hospice Services	See Page		of	
Private-Duty Nursing	See Page		of	
Urgent Care Centers or Facilities	See Page		of	
Home Health Care Services	See Page		of	
Emergency Room Services	See Page		of	
Emergency Transportation/Ambulance	See Page		of	
Inpatient Hospital Services (e.g., Hospital Stay)	See Page		of	
Inpatient Physician and Surgical Services	See Page		of	
Skilled Nursing Facility	See Page		of	
Prenatal and Postnatal Care	See Page		of	
Delivery and All Inpatient Services for Maternity Care	See Page		of	
Mental/Behavioral Health Outpatient Services	See Page		of	
Mental/Behavioral Health Inpatient Services	See Page		of	
Substance Abuse Disorder Outpatient Services	See Page		of	
Substance Abuse Disorder Inpatient Services	See Page		of	
Generic Drugs	See Page		of	
Preferred Brand Drugs	See Page		of	
Non-Preferred Brand Drugs	See Page		of	
Specialty Drugs	See Page		of	
Outpatient Rehabilitation Services	See Page		of	
Habilitation Services	See Page		of	
Chiropractic Care	See Page		of	
Durable Medical Equipment	See Page		of	
Imaging (CT/PET Scans, MRIs)	See Page		of	
Preventive Care/Screening/Immunization	See Page		of	

Routine Eye Exam for Children	See Page		of	
Eye Glasses for Children	See Page		of	
Dental Check-Up for Children	See Page		of	
Rehabilitative Speech Therapy	See Page		of	
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page		of	
Well Baby Visits and Care	See Page		of	
Laboratory Outpatient and Professional Services	See Page		of	
X-rays and Diagnostic Imaging	See Page		of	
Basic Dental Care – Child	See Page		of	
Orthodontia – Child	See Page		of	
Major Dental Care – Child	See Page		of	
Transplant	See Page		of	
Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
Nutritional Counseling	See Page		of	
Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

I, on behalf of _____hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by_____ for review and approval.

_____ _____ _____

Name: Title: Date:

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: _____

_____

HIOS Product IDs: _____

_____

Applicable HIOS Plan IDs (Standard Component): _____

_____

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

_____

_____

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

_____

Confirmation that only in-network cost sharing, including multitier networks, was considered:

_____

Description of the standardized plan population data used:

_____

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

_____

_____

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

_____

_____

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: _____

Actuary Printed Name: _____

Date: _____

Indiana
Part III - Federal Actuarial Memorandum
All Savers Insurance Company
NAIC Number: 0707-82406
FEIN: 35-1665915
HIOS Issuer ID: 36373

Purpose

Following is a rate filing prepared by All Savers Insurance Company. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services. The purpose of this memorandum is to provide information relevant to Part I - Unified Rate Review Template.

This filing establishes the rates intended to be used for individual On-Exchange health benefit plans in Indiana for 2015.

This memorandum is intended solely for the information of and use by the Department of Health & Human Services and the Indiana Department of Insurance. It will demonstrate compliance with state and federal laws and regulations and is not intended to be used for any other purpose.

General Information

Company Identifying Information

Company Legal Name:	All Savers Insurance Company
State:	Indiana
HIOS Issuer ID:	36373
Market:	Individual
Effective Date:	January 1, 2015

Company Contact Information

Primary Contact Name:	James M. Shallow, ASA, MAAA
Primary Contact Telephone Number:	(920) 661-1071
Primary Contact Email Address:	jshallow@unitedhealthone.com

Proposed Rate Increase

This is an initial filing. No rate increase is requested at this time.

Experience Period Premium and Claims

All Savers Insurance Company has no existing individual market business in Indiana. Therefore, no historical claims experience exists. Since the Unified Rate Review Template requires entry of data in this section, amounts of $1 were entered so the spreadsheet could be validated and submitted.

Benefit Categories

All Savers Insurance Company has no existing individual market business in Indiana. Therefore, no historical claims experience exists.

Projection Factors

All Savers Insurance Company has no existing individual market business in Indiana. Therefore, no historical claims experience exists, and no adjustment factors were applied.

Credibility Manual Rate Development

Source and Appropriateness of Data Used

These rates are intended to be used on a guarantee issue basis. As All Savers Insurance Company does not have relevant historical experience for individual medical guarantee issue products, we relied on the guarantee issue claims experience and rate development of affiliated small group carriers to develop the credibility manual rate.

The experience used in the development of these rates is net of the appropriate coordination of benefit recoveries. Therefore, the rates reflect the necessary equitable reduction in premiums or costs to beneficiaries of such other insurance or contract rights.

Data Adjustments

1. Estimated Morbidity Differential of the Population Insured

   A key assumption in our manual rate development was the estimated morbidity differential between the individual and small group markets. Our judgment was that historical morbidity differentials for very small size employer groups versus the small group overall average would be an appropriate indicator for this morbidity differential. The chart below shows the historical experience of affiliated small group carriers for the following group sizes: 1-employee, 1-3 employees, and 1-50 employees. While historical morbidity for 1-employee groups could indicate a morbidity load of greater than 100%, we realize that this reflects a level of anti-selection due to the fact that the primary alternative market for these members was the highly underwritten individual market. In the post-2014 guarantee issue environment for the individual market, although we do expect there will still be some anti-selection in the individual market relative to the small group market, we do not anticipate it being quite this high. Additionally, the new products will include more extensive care management.

   Therefore, considering the above along with the potential impact of Medicaid spend-down on the individual exchange market in Indiana, we have assumed morbidity for this product of 1.10 times that of a comparable small group product before removing small group adjustments made due to early renewals and small employer market dropout that are not applicable to these individual plans.

Nationwide Experience

Small Group Size	Earned Premium	Incurred Claims	Member Months	Premium PMPM	Claims PMPM	Claims vs 1-50 ees
1ee	45,744,151	58,576,101	87,361	$523.62	$670.51	2.221
1-3ees	410,313,807	379,506,863	855,464	$479.64	$443.63	1.470
1-50ees	6,028,225,051	4,519,101,029	14,970,587	$402.54	$301.87	1.000

Morbidity Load Assumption: 1.10

2. Trend / Emerging Experience

   The manual rates were developed from an affiliated carrier's small group projections for the 2014 calendar year. They were adjusted for trend factors and emerging claims experience.

3. Benefit Differential

   Adjustments were made to the affiliated small group carrier's experience to reflect the benefit variations between the small group portfolio and our individual product. Additional adjustments were made to reflect changes in the preferred drug list.

4. Network Adjustments

   The affiliated carrier's small group projections for the 2014 calendar year include EPO experience. The individual plans included in this filing are EPO plans as well, so no adjustments for network differential were necessary.

5. Demographic Adjustment

   We anticipate our individual exchange business to have a different age/gender composition compared to that of the affiliated small group carrier's business. Therefore, an adjustment was made to the manual rate development to account for the difference in demographic mix.

Credibility of Experience

All Savers Insurance Company has no existing individual market business in Indiana, so zero credibility is applied to the base period experience. We believe the affiliated small group experience used for developing the manual rates to be fully credible. A specific credibility formula was not used for this determination, but rather informed actuarial judgment. As ASOP 25, section 3.4 states: "Professional Judgment – The actuary should use professional judgment when selecting, developing, or using a credibility procedure. The use of credibility procedures is not always a precise mathematical process."

Paid-to-Allowed Ratio

A paid-to-allowed ratio was estimated for each plan by trending an affiliated carrier's small group claims experience to 2015 and accounting for the variation in cost-sharing parameters. These ratios were weighted by the projected membership per plan to calculate the average paid-to-allowed factor shown in Worksheet 1 of the Unified Rate Review Template.

Risk Adjustment and Reinsurance

Projected Risk Adjustments Net of Risk Adjustment User Fees

We are assuming zero net payments for risk adjustments. The HHS Notice of Benefit and Payment Parameters for 2015 specifies a risk adjustment user fee of $0.08 PMPM.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

Reinsurance recoveries are expected to be 7.9% of incurred claims. This amount was derived using nationwide experience from an affiliated carrier trended to 2015. The recoveries were then calculated using the 2015 reinsurance parameters, as published in the HHS Notice of Benefit and Payment Parameters for 2015. The HHS Notice of Benefit and Payment Parameters for 2015 specifies a reinsurance premium of $3.67 PMPM.

Non-Benefit Expenses and Profit

Administrative Expense Load

The 9.65% administrative expense load includes: commissions, credit card fees, quality improvements, and SG&A.

1. Commissions: We anticipate an average commission rate of approximately 2.50% of premium for 2015.
2. Quality Improvements: We assumed 0.90% of premium for quality improvements based on data from an affiliated carrier.
3. SG&A: Our general and administrative expense assumption is based on experience of our affiliated small group carriers, adjusted for inflation and expected 2015 expense level. For this product in the state of Indiana, this equates to approximately 6.25% of premium for 2015.

Profit & Risk Margin

Our projected underwriting gain over the 2015 rating period is approximately 2.2% of premium.

Premium	100.0%
Claims	-84.7%
Reinsurance Recoveries	6.7%
Risk Adjustment Payments	0.0%
Premium Tax	-1.3%
Reinsurance Fees	-0.9%
Risk Adjustment User Fee	-0.0%
Insurer Fees	-2.1%
Exchange Fees	-3.5%
PCORI Fees	-0.0%
Commissions	-2.5%
Quality Improvements	-0.9%
SG&A	-6.3%
Pre-Tax Income:	**4.5%**
Income Tax *	-2.3%
After-Tax Income:	**2.2%**

**Income Tax is calculated as 35% * (Pre-Tax Income + Insurer Fees).*

***Figures may not tally due to rounding of display in the exhibit.*

Taxes and Fees

The 9.29% attributed to taxes and fees includes: premium tax, insurer fees, exchange fees, PCORI fees, and federal income tax.

1. Premium Tax: The premium tax rate is 1.3%.
2. Insurer Fees: Each insurance carrier's assessment of insurer fees will be based on earned health insurance premium in the prior year, with certain exclusions. UnitedHealthcare (parent company of All Savers Insurance Company) estimates that 2.13% of its 2015 premium will be allocated for insurer fees.
3. Exchange Fees: Exchange fees in the state of Indiana are 3.50%.
4. PCORI Fees: This product will be effective for the 2015 plan year. The PCORI fee is $2 per member per year, or $0.17 PMPM. For this product in the state of Indiana, this equates to approximately 0.04% of premium.
5. Federal Income Tax: Income tax is projected to be 2.32% of premium and is calculated as 35% * (Pre-Tax Income + Insurer Fees), since insurer fees are not tax deductible.

Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2015 is 87.8%.

Claims	84.7%
Quality Improvements	0.9%
Reinsurance Recoveries	-6.7%
Risk Adjustment Payments	0.0%
Total MLR Claims	**78.9%**
Premium	100.0%
Premium Tax	-1.3%
Income Tax	-2.3%
Reinsurance Fee	-0.9%
Insurer Fees	-2.1%
Exchange Fees	-3.5%
PCORI Fee	-0.0%
Risk Adjustment User Fees	-0.0%
Total MLR Premium	**89.8%**
MLR:	**87.8%**

**Income Tax is calculated as 35% * (Pre-Tax Income + Insurer Fees).*

***Figures may not tally due to rounding of display in the exhibit.*

Single Risk Pool

The single risk pool reflects all covered lives for every individual non-grandfathered product and plan combination for All Savers Insurance Company in the state of Indiana. It is established in accordance with the requirements of 45 CFR part 156, 156.80(d).

Index Rate

The index rate represents 99.95% of the projected allowed claims PMPM for this block of business. Benefits in excess of essential health benefit requirements include routine foot care for diabetics, which are anticipated to account for 0.05% of claims. The index rate for the projection period is $485.61.

Market Adjusted Index Rate

The market adjusted index rate includes market-wide adjustments for the federal reinsurance program, risk adjustment, and exchange user fees. The total expected impact for reinsurance recoveries and reinsurance fees is $24.60 PMPM. The total impact for risk adjustment payments and user fees are expected to be $0.08 PMPM. Please refer to the 'Risk Adjustment and Reinsurance' section for a brief description. Exchange user fees are approximately $14.79 PMPM. Please refer to the 'Non-Benefit Expenses and Profit' section for a brief description.

Since the Index Rate is at an allowed claim level and the reinsurance and risk adjustment values are at a paid level, the reinsurance and risk adjustment values are first divided by the Paid to Allowed Average Factor to compute the market adjustment. The market adjustment is then added to the Index Rate to yield the Market Adjusted Index Rate. The resulting market adjusted index rate is $472.40.

Index Rate	$485.61
Market Adjustment = ($14.79 + $0.08 - $24.60) / (0.737)	- $13.21
Market Adjusted Index Rate	$472.40

**Figures may not tally due to rounding of display in the exhibit.*

Plan Adjusted Index Rates

The plan adjusted index rates for each plan are listed below. They were calculated by beginning with the market adjusted index rate and adjusting for all allowable plan modifiers. The index rates vary due to different actuarial values and cost sharing designs by plan. The weighted average, based on projected membership, is $422.58.

- Gold Compass 1250: $469.97
- Silver Compass HSA 2600: $413.34
- Silver Compass 2000: $424.91
- Silver Compass 3500-1: $429.05
- Silver Compass 5000: $429.46
- Bronze Compass HSA 4900: $352.16
- Bronze Compass 5500: $388.54

The calculation for the *Gold Compass 1250 plan* is as follows:

Market Adjusted Index Rate	$472.40
Benefits in addition to EHB	+ $ 0.24
	$472.64
Paid to Allowed Average Factor	x 0.737
	$348.15
Distribution and Admin (Incl. Fees & Costs)	+ $74.43
	$422.58
Actuarial Value & Cost Share=(Pricing AV=1.137)/(Avg=1.022)	x 1.112
Plan Adjusted Index Rate	$469.97

**Figures may not tally due to rounding of display in the exhibit.*

Calibration

Calibration adjustments include age and geography, and they do not vary by plan.

Age Curve Calibration

The age calibration is 1.444, which is based on an average age assumption of 45 years. The HHS unisex age factors, included in Attachment A, were used.

Geographic Factor Calibration

The geographic factor calibration is 0.7402, which is based on our expected distribution of covered individuals. Attachment A includes the geographic factors for each of the counties in which All Savers Insurance Company intends to market this product. Geographic factors are based on experience from an affiliated carrier and include adjustments for differences in our provider networks.

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for each plan that is charged to an individual before applying the rating adjustments of age, area, and tobacco status. It is developed by calibrating the plan adjusted index rate for age and geography, and adjusting for any additional allowable rating factors specified by 45 CFR Part 147.102 (including tobacco).

Tobacco Adjustment

The tobacco adjustment is 1.007, which is based on the expected average tobacco factor (1.000 for non-tobacco users) for our expected distribution of covered individuals. See Attachment A for the tobacco factors by age.

Consumer Adjusted Premium Rates

The Consumer Adjusted Premium Rate is calculated as the Plan adjusted Index Rate divided by the product of the calibration factors and tobacco adjustment. Results for each plan are listed below. The weighted average, based on projected membership, is $392.61.

- Gold Compass 1250: $436.64
- Silver Compass HSA 2600: $384.03
- Silver Compass 2000: $394.78
- Silver Compass 3500-1: $398.62
- Silver Compass 5000: $399.00
- Bronze Compass HSA 4900: $327.19
- Bronze Compass 5500: $360.99

AV Metal Values

Our plan designs include post deductible copays in addition to per-occurrence copays paid in conjunction with coinsurance rates. Neither of these benefit designs are directly compatible with the AV calculator. For these unique plan designs, the alternate method described in 45 CFR 156.135(b)(2) was used for the AV calculations. Following is a description of how the inputs for these unique benefits were modified to fit the parameters of the AV calculator.

Per-Occurrence Copays Paid in Conjunction with Coinsurance Rates

In order to modify the inputs for this type of benefit design to fit the parameters of the AV calculator, the following formula was used to estimate the insurer's cost share.

$$\text{Effective Insurer Coinsurance Rate} = \left(1 - \frac{\text{Member Copay}}{\text{Average Unit Cost}}\right) * (1 - \text{Member Coinsurance Rate})$$

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. If the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. All enrollees within a continuance table were included in the calculation of the average unit cost for each benefit type.

The calculation of the average unit cost for the Outpatient Facility Fee is the one exception to the above methodology. Since the per-occurrence copay does not apply to all services included in the OP Facility Fee category within the AV calculator, the continuance tables did not provide the detail necessary for this calculation. Therefore, the average unit cost for the Outpatient Facility Fee was based on the historical experience of affiliated carriers in addition to our proprietary pricing model.

Post Deductible Copays

In order to modify the inputs for this type of benefit design to fit the parameters of the AV calculator, the following formula was used to estimate the insurer's cost share.

$$\text{Effective Insurer Coinsurance Rate} = \left(1 - \frac{\text{Member Copay}}{\text{Average Unit Cost}}\right)$$

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. If the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. Only those enrollees with claims greater than the plan deductible will pay the post deductible copay. Therefore, only those enrollees with total spending greater than the specified plan deductible were included in the calculation of the average unit cost for each benefit type.

Our prescription drug benefits are based on a drug categorization of Tier 1 to Tier 4, instead of the categories presented in the AV calculator (i.e. Generic, Preferred Brand, Non-Preferred Brand and Specialty). In addition, our Tier 3 and Tier 4 prescription drug benefits incorporate coinsurance rates along with minimum copay amounts. Based on historical experience of affiliated carriers and our expectations regarding the organization of brand and generic drugs into Tiers, the prescription drugs were re-categorized to match the parameters of the AV calculator, and the benefits were converted to equivalent member copays for each category. If the copay applies after the deductible, the equivalent member copay was then entered in the formula presented above in order to calculate the effective insurer coinsurance rate for each prescription category.

Benefits that Vary Based on Place of Service

For some types of services, our plan designs include different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility). To incorporate this differentiation in benefits, the Narrow Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

Plans Impacted by Alternative Methodology

The chart in Attachment B outlines which benefit adjustments were made to each plan included in this product.

Family Benefits

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

AV Pricing Values

The Silver Compass HSA 2600 plan is the fixed reference plan selected as the basis for the AV Pricing Values, with a pricing value of 1.000. The variation in rating factors for the other plans is based on the actuarial value and cost-sharing design differentiation relative to the Silver Compass HSA 2600 plan.

The medical plan price relativities were developed using the proprietary UnitedHealthcare pricing model. This model uses UnitedHealthcare nationwide experience data which is fully credible. Claim data is then projected to the pricing period based on national projections of utilization and unit costs. These projections are done at the service category level (inpatient, outpatient, etc.). Benefit design parameters such as deductibles, copays, and coinsurance rates are applied to the claim distributions of the matching service category. Cost-sharing is applied, and the values of each service category are summed to determine an overall benefit value. This overall benefit value is then compared to a base benefit design to calculate the plan relativity. All benefit plans are priced consistently with each other, with the rates differing only by the estimated value of the benefit differences.

In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations. The plan specific adjustments to the market wide index rate do not reflect differences in health status or risk selection.

Membership Projections

Since this is a new product with no historical experience, membership was estimated based on informed judgment.

Terminated Products

No products are being terminated at this time. All Savers Insurance Company has no existing individual market business.

Plan Type

A plan type of EPO has been selected for each plan, which describes the plans exactly.

Warning Alerts

There are no Warning Alerts in Worksheet 2 of the Unified Rate Review Template.

Reliance

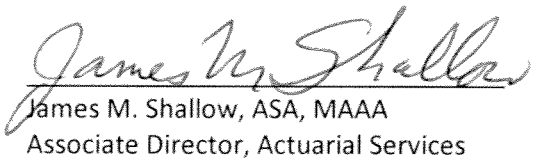
Due to responsibility allocation, I relied on other UnitedHealthcare actuaries that have responsibility for small group rate development to provide the affiliated carrier experience data and rate development procedure for the small group rates.

Actuarial Certification

I, James M. Shallow, am an Associate Director of Actuarial Services for United Healthcare's Individual Line of Business, which includes All Savers Insurance Company's health insurance products marketed to individuals. I am a member of the American Academy of Actuaries, and I meet the Academy's qualification standards for rendering statements of actuarial opinion, with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment:

- The projected index rate is in compliance with all applicable state and federal statutes and regulations, and it was developed in compliance with the applicable Actuarial Standards of Practice.
- The benefits are reasonable in relation to the premiums charged and the population anticipated to be covered. In addition, premiums are not inadequate, excessive, or unfairly discriminatory.
- Only the allowable modifiers were used to generate plan level rates.
- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Unified Rate Review Template. The alternate method described in 45 CFR 156.135(b)(2) was used to fit the parameters of the AV calculator.
- The Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges, and for certification that the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers.



James M. Shallow, ASA, MAAA
Associate Director, Actuarial Services

6.11.14
Date

Attachment A:

Age	Age Factor	Tobacco Factor
<=20	0.635	1.00
21	1.000	1.05
22	1.000	1.05
23	1.000	1.05
24	1.000	1.05
25	1.004	1.05
26	1.024	1.05
27	1.048	1.05
28	1.087	1.05
29	1.119	1.05
30	1.135	1.05
31	1.159	1.05
32	1.183	1.05
33	1.198	1.05
34	1.214	1.05
35	1.222	1.10
36	1.230	1.10
37	1.238	1.10
38	1.246	1.10
39	1.262	1.10
40	1.278	1.10
41	1.302	1.10
42	1.325	1.10
43	1.357	1.10
44	1.397	1.10
45	1.444	1.10
46	1.500	1.10
47	1.563	1.10
48	1.635	1.10
49	1.706	1.10
50	1.786	1.20
51	1.865	1.20
52	1.952	1.20
53	2.040	1.20
54	2.135	1.20
55	2.230	1.20
56	2.333	1.20
57	2.437	1.20
58	2.548	1.20
59	2.603	1.20
60	2.714	1.20
61	2.810	1.20
62	2.873	1.20
63	2.952	1.20
64+	3.000	1.20

Rating Area	County	Area Factor
Rating Area 1	Lake LaPorte Porter	0.827
Rating Area 2	Elkhart Kosciusko Marshall St. Joseph Starke	0.704
Rating Area 3	Adams DeKalb Huntington Lagrange Noble Steuben Wabash Wells Whitley	0.690
Rating Area 4	Allen	0.690
Rating Area 5	Benton Jasper Newton Warren White	0.710
Rating Area 6	Cass Fulton Howard Miami Pulaski	0.724
Rating Area 7	Carroll Clinton Fountain Montgomery Putnam Tippecanoe Tipton	0.723
Rating Area 8	Blackford Delaware Grant Jay Randolph	0.745
Rating Area 9	Clay Parke Sullivan Vermillion Vigo	0.786

Rating Area	County	Area Factor
Rating Area 10	Boone Hamilton Hendricks Marion Morgan Shelby	0.786
Rating Area 11	Fayette Hancock Henry Madison Union Wayne	0.760
Rating Area 12	Bartholomew Decatur Jackson Jennings Rush	0.689
Rating Area 13	Brown Johnson Lawrence Monroe Owen	0.717
Rating Area 14	Dearborn Franklin Ohio Ripley Switzerland	0.787
Rating Area 15	Daviess Dubois Greene Knox Martin Orange Perry Pike Spencer	0.670
Rating Area 16	Clark Crawford Floyd Harrison Jefferson Scott Washington	0.574
Rating Area 17	Gibson Posey Vanderburgh Warrick	0.731

Attachment B:

Plan Name	Per-Occurrence Copays Paid in Conjunction with Coinsurance Rates	Post Deductible Copays
UnitedHealthcare Gold Compass 1250	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Silver Compass HSA 2600	*Not Applicable*	- Generic Drugs - Preferred Brand Drugs - Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Silver Compass 2000	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Silver Compass 3500-1	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Silver Compass 5000	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Bronze Compass HSA 4900	*Not Applicable*	- Generic Drugs - Preferred Brand Drugs - Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Bronze Compass 5500	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Generic Drugs - Preferred Brand Drugs - Non-Preferred Brand Drugs - Specialty Drugs

All Savers Insurance Company

Choice Individual Medical Policy

7440 Woodland Drive

Indianapolis, Indiana 46278-1719

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if we refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, or there is fraud or a material misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

10-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

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

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

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

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

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

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

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

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

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

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

Don't Hesitate to Contact Us

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

Your Responsibilities

Be Enrolled and Pay Required Premiums

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

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

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

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

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

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

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

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

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

1. Ambulance Services

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

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

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

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

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

3. Diabetes Services

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

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

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

Diabetic Self-Management Items

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

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

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

- Not of use to a person in the absence of a disease or disability.

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

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

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

Benefits are available for repairs and replacement, except that:

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

5. Emergency Health Services - Outpatient

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

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

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

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

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

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

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

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

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

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

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

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

9. Lab, X-Ray and Diagnostics - Outpatient

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

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

Benefits under this section include:

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

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

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

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

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

Benefits under this section include:

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

11. Mental Health Services

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

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

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

12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services

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

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

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.

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

- Diagnostic evaluations and assessment.
- Treatment planning.

- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

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

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

13. Pharmaceutical Products - Outpatient

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

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

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

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

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

14. Physician Fees for Surgical and Medical Services

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

15. Physician's Office Services - Sickness and Injury

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

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

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

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

Benefits under this section include allergy injections.

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

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

16. Pregnancy - Maternity Services

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

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

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

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

17. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on

how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

18. Prosthetic Devices

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

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

19. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

20. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

21. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

23. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

24. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

25. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), chemotherapy (whether administered orally, intravenously, or by injection) or other intravenous infusion therapy and radiation oncology.

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

26. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

27. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

28. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

29. Autism Spectrum Disorder Medical Services

Benefits are provided for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by a treating Physician.

Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

30. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

31. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

32. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

33. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

34. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

35. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

36. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly associated with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.

- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

   Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

   - The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
   - The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.
18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.
19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.

6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Neurodevelopmental Disorders - Autism Spectrum Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

7. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.

- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
15. In vitro fertilization regardless of the reason for treatment.

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 residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Fetal reduction surgery.
6. Abortion, except for Therapeutic Abortion.

P. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Q. Substance-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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

R. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

S. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation

for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:
   - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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.

- **You Accept Reimbursement for Premium**

  You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:

  - Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
  - Indian tribes, tribal organizations or urban Indian organizations
  - State and Federal Government programs.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Assistance

A toll free telephone number is available for a Covered Individual to obtain information about filing Grievances.

- The individuals that answer the toll free telephone number can assist the caller or forward the call to the appropriate department if additional information is needed.
- Calls can be received at least 40 normal business hours per week and at other times the calls will be recorded by voicemail.
- If a call is left on voicemail, a qualified individual will respond to the call the next business day after the call is received.
- The calls will be answered by individuals who speak the English language. Non-English languages will be translated through a third party translation service.

Assistance is also available for Covered Individuals with literacy, physical, health, or other impediments.

Initial Utilization Review Determinations

Within 2 business days after receiving a request for a Utilization Review Determination that includes all information necessary to complete the Utilization Review Determination, we or a Utilization Review agent acting on our behalf, will notify the Covered Individual of the Utilization Review Determination by mail or another means of communication.

If the Utilization Review Determination does not certify an admission, a service, or a procedure, the notice will include:

- If the Utilization Review Determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination;
- The procedures to file a Grievance; and
- The toll free telephone number that the Covered Individual may call to request a review of the determination or obtain further information about the right to file a Grievance.

Internal Review of Grievances

Non-Urgent Care Review Request: A Covered Individual has 180 days following receipt of an initial notification of a determination to file a Grievance orally or in writing.

Urgent Care Review Request: Expedited reviews are available for Grievances regarding urgent care.

- **Acknowledgement:** An acknowledgement of the Grievance, given orally or in writing, must be provided by us within 5 business days after receipt of the Grievance. The notice must include:
- The name, address, and telephone number of an individual to contact regarding the Grievance; and
- The date the Grievance was filed.

Reviewer's Requirements:

- All Grievances regarding urgent care will be reviewed by a physician.
- A Grievance regarding appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a panel of one or more qualified individuals appointed by us.

- The panel must include one or more individuals who:
  - Have knowledge of the medical condition, procedure, or treatment at issue;
  - Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment or service;
  - Were not involved in the original determination; and
  - Do not have a direct business relationship with the Covered Individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.
- The Covered Individual will be given the opportunity to appear in person before the panel or if unable to appear in person, otherwise appropriately communicate with the panel. The Covered Individual will be notified not less than 72 hours prior to the meeting of the panel.
- The panel will meet during normal business hours and at a place convenient to a Covered Individual who wishes to appear before or otherwise communicate with the panel.

- All other Grievances that are based in whole or in part on a medical judgment will be reviewed by a health care professional who has appropriate expertise in the field of medicine involved in the medical issue, was not involved in the original determination, and is not the subordinate of the original reviewer.
- If the Grievance concerns a Rescission action, a panel of individuals who were not involved in the original determination and who are not the subordinates of the original reviewer will review the Grievance.
- All other Grievances will be reviewed by an impartial person who was not involved in making the original determination, is not the subordinate of the original reviewer, and has sufficient experience, knowledge, and training to appropriately resolve the Grievance.

General Information:

- Covered Individuals have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
- Covered Individuals have the right to review the claim file and to present evidence and testimony as part of the internal review process.
- Covered Individuals may request reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge.
- All comments, documents, records and other information submitted by the Covered Individual relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial benefit determination, will be considered in the internal Grievance review.
- The Covered Individual will receive from us, as soon as possible, any new or additional evidence considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new information.
- The Covered Individual will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

- A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.
- The internal appeal process must be exhausted before the Covered Individual may request an external review, unless:
    - The plan provides a waiver of this requirement;
    - The plan fails to follow the appeal process; or
    - The Covered Individual files an urgent care external appeal at the same time as an urgent care internal appeal.
- Resolution Timeframe:
- A Grievance regarding non-urgent care must be resolved as expeditiously as possible, reflecting the clinical urgency of the situation, but no later than:
    - 45 days after the Grievance regarding Post-service Claims is filed; or
    - 30 days after the Grievance regarding Pre-service Claims is filed.
- We will first orally notify the Covered Individual of the Grievance decision regarding urgent care within:
    - 48 hours after the Grievance regarding a Utilization Review Determination is filed and all the information necessary to complete the review is received, or 72 hours after the Grievance is received, whichever is earlier; or
    - 72 hours for all Grievances that are not regarding Utilization Review Determinations.
- The oral notification will be followed by a written notice as described in the Notification of Determination provision below.

Notification of Determination: We will notify a Covered Individual in writing of the resolution of the Grievance immediately for Grievances regarding Pre-service Claims or within 5 business days after completing an investigation of a Grievance regarding Post-service Claims. The notice must include:

- A statement of our understanding of the Covered Individual's Grievance;
- The decision reached by us;
- The contractual basis for the decision, including reference to specific plan provisions on which the determination is made;
- If applicable, the medical rationale for the resolution stated in sufficient detail for the Covered Individual to respond further to our position;
- Reference to the evidence or documentation used as the basis for the resolution, including a statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Individual's claim for benefits;
- The specific reason or reasons for the determination;
- A statement that the Covered Individual may have a right to bring a civil action under state or federal law;
- The specific rule, guideline, protocol, or other similar criterion, if used to make the determination, or that it will be provided free of charge upon request;
- The date of service;
- The health care provider's name;

- The claim amount;
- The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
- Our denial code with corresponding meaning;
- A description of any standard used, if any, in denying the claim;
- The department, address, and telephone number through which a Covered Individual may contact a qualified representative to obtain additional information about the decision or the next level of appeal available to them;
- If the Grievance is regarding appropriateness, medical necessity, experimental or investigational treatment or a Rescission:
    - Notice of the Covered Individual's right to external review by an independent review organization (IRO), including a description of the external review procedure; and
    - A copy of the Indiana Authorization Form which authorizes us to disclose protected health information for the external review; and
    - The plan must provide for the identification of medical experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the determination; and
- If applicable:
    - That assistance is available by contacting the specific state's consumer assistance department; and
    - A culturally linguistic statement based upon the Covered Individual's county or state of residence that provides for oral translation of the determination.

External Review

Non-Expedited Request:

- After exhausting the internal Grievance process, a Covered Individual has 120 days after notice of the second-level review resolution to request an external review in writing. A request for external review may only be made for a Grievance regarding:
    - A determination that a service or proposed service it not appropriate or Medically Necessary;
    - A determination that a service or proposed service is experimental or investigational; or
    - Our decision to Rescind an accident and sickness insurance policy.
- The Covered Individual is permitted to submit additional information regarding the proposed service throughout the external review process.
- The Covered Individual must sign an authorization form to release necessary medical information.

Expedited Request: An expedited request maybe made for Grievances related to a Sickness, disease, condition, Injury, or disability if the time frame for a standard review would seriously jeopardize the Covered Individual's:

- Life or health; or
- Ability to reach and maintain maximum function.

Procedure:

- When a request for external review is filed, we will:

- Select an IRO from a list of IROs that are certified by the Department of Insurance (DOI); and
- Rotate the choice of an IRO among all certified IROs before repeating a selection.

- We will cooperate with the IRO by promptly providing the IRO with any information requested by the IRO.
- If, at any time during an external review, the Covered Individual submits information to us that is relevant to our resolution and was not previously considered, we may reconsider the previous resolution.
  - The IRO will cease the external review process until the reconsideration is completed.
  - We will notify the Covered Individual of the decision within 15 business days after the information is submitted (72 hours for an expedited review).
  - If our decision is adverse to the Covered Individual, the Covered Individual may request that the IRO resume the external review.
- If we choose not to reconsider, we will forward the submitted information to the IRO within 2 business days after receipt.

Resolution Timeframe and Notification of Determination:

- The IRO will make a determination to uphold or reverse our determination within 15 business days (3 business days for expedited) after the request for external review is filed. The IRO will base their determination on information gathered from the Covered Individual or the Covered Individual's designee, us, and the treating health care provider, and any additional information that the IRO considers necessary and appropriate.
- The IRO will notify us and the Covered Individual of their determination within 72 hours (24 hours for expedited) of making the determination.

General Information:

- An external review decision is binding on us.
- We will pay for all costs of the external review by the IRO.

Definitions

As used in this section, the following terms have the meanings indicated.

Authorized Representative means:

- A person to whom a Covered Individual has given express written consent to represent the Covered Individual;
- A person authorized by law to provide substituted consent for a Covered Individual; or
- A family member of the Covered Individual or the Covered Individual's treating health care professional when the Covered Individual is unable to provide consent.

For purposes of these procedures, a reference to a Covered Individual may also refer to an Authorized Representative.

Covered Individual means an individual who is covered under an accident and sickness insurance policy. For purposes of these procedures, and where applicable, a Covered Individual may also include:

- An Authorized Representative of the Covered Individual; and
- A Provider Of Record acting on behalf of the Covered Individual.

Grievance means any dissatisfaction expressed by or on behalf of a Covered Individual regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is experimental or investigational;
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between:
    - A Covered Individual and us; or
    - A group policyholder and us; or
- Our decision to Rescind an accident and sickness insurance policy;

and for which the Covered Individual has a reasonable expectation that action will be taken to resolve or reconsider the matter than is the subject of dissatisfaction.

Notification Involving Urgent Care means a Grievance that meets any of the following conditions:

- The time periods for making non-urgent care review recommendations:
    - Could seriously jeopardize the life or health of the Covered Individual or the ability of the Covered Individual to regain maximum function; or
    - In the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
- Other than above, the decision as to whether a condition involves urgent care is to be determined by the attending provider, and we must defer to such determination of the attending provider.

Pre-service Claim means any claim for benefits for medical care or treatment that requires our approval in advance of the Covered Individual obtaining the medical care.

Provider Of Record means the physician or other licensed practitioner identified to a Utilization Review agent as having primary responsibility for the care, treatment, and services rendered to a Covered Individual.

Post-service Claim means any claim for benefits for medical care or treatment that is not a Pre-service Claim.

Rescind or **Rescission** means a cancellation or discontinuance of coverage by us that has a retroactive effect.

Utilization Review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a Covered Individual. The term does not include:

- Elective requests for clarification of coverage, eligibility, or benefits verification; or
- Medical claims review.

Utilization Review Determination means the rendering of a decision based on Utilization Review that denies or affirms either of the following:

- The necessity or appropriateness of the allocation of resources; or
- The provision or proposed provision of health care services to a Covered Individual.

The term does not include the identification of alternative, optional medical care that requires the approval of the Covered Individual and does not affect coverage or benefits if rejected by the Covered Individual.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive authority to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, as we determine, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.

- ♦ Provided in a clinically controlled research setting.
- ♦ Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

June 11, 2014

Attention:

Subject: **All Savers Insurance Company**
Filing of Individual Health Rates
SERFF Tracking Number: UHLC-129514067
State Tracking Number: IEXPOL.I.15.IN

Mr. Knable:

Thank you for your letter dated May 28, 2014. I have addressed your concerns below.

1. In the Data Adjustment section 2, please provide the trend used and provide a path from the manual rates to those adjusted for trend and emerging claims.

   We assumed an annual claims trend of 9.5%.

   Forward-looking medical expense estimates are based on a number of considerations. In general, recent/emerging claims experience and contracted rates with facilities and providers are reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

2. In the Data Adjustment section 3, what are the specific adjustments made to the small group portfolio?

   There was a -3.0% adjustment to account for the differences in pharmacy network (-.5%) and Prescription Drug List (PDL) variations (-2.5%).

3. In the Data Adjustment section 5, please provide the demographic information and show how the adjustment was developed.

   The demographic adjustment is 3% and is due to the anticipated difference in demographic mix between our individual business and the affiliated carrier's small group business.

   The Small Business (SB) ideal pricing age/gender factors were scaled such that applying the SB demographic mix would yield the same average as applying the distribution to the HHS 3:1 age factors. Any scaling adjustment would be included in the SB base rate.

   Then, applying the anticipated *individual* demographic mix to both the HHS 3:1 age factor and the Ideal SB Pricing Factor indicated that we expect to be about 3% short in rate (average factor of 1.70 vs. need 1.75). Please see tables below. Thus, we adjust our base rate by 3%.

2015 IB Pricing - Age/Gender Analysis

	HHS' 3:1 Factor			SB Ideal Pricing Factor (scaled)			SB Distribution		
Age	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-20	0.635	0.635	0.635	0.697	0.754	0.725	13%	12%	25%
21-24	1.000	1.000	1.000	0.506	1.034	0.758	3%	3%	6%
25-29	1.056	1.056	1.056	0.541	1.295	0.895	4%	4%	8%
30-34	1.178	1.178	1.178	0.637	1.431	1.001	5%	4%	9%
35-39	1.240	1.240	1.240	0.822	1.471	1.119	5%	4%	8%
40-44	1.332	1.332	1.332	1.050	1.525	1.273	5%	4%	9%
45-49	1.570	1.570	1.570	1.391	1.775	1.572	5%	4%	9%
50-54	1.956	1.956	1.956	1.912	2.157	2.027	5%	5%	10%
55-59	2.430	2.430	2.430	2.485	2.489	2.487	4%	4%	9%
60-64	2.870	2.870	2.870	3.296	3.120	3.213	3%	3%	6%
65+	3.000	3.000	3.000	3.523	2.862	3.247	1%	1%	2%
Average	1.398	1.382	1.391	1.249	1.549	1.391	53%	47%	100%

	HHS' 3:1 Factor			SB Ideal Pricing Factor (scaled)			Individual Distribution *		
Age	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-20	0.635	0.635	0.635	0.671	0.810	0.742	5%	5%	10%
21-24	1.000	1.000	1.000	0.506	1.034	0.803	2%	3%	5%
25-29	1.060	1.059	1.059	0.541	1.295	0.955	4%	4%	8%
30-34	1.178	1.178	1.178	0.637	1.431	1.071	4%	5%	9%
35-39	1.240	1.240	1.240	0.822	1.471	1.187	4%	4%	8%
40-44	1.332	1.332	1.332	1.050	1.525	1.317	4%	4%	8%
45-49	1.570	1.570	1.570	1.391	1.775	1.611	5%	6%	11%
50-54	1.956	1.956	1.956	1.912	2.157	2.053	5%	6%	11%
55-59	2.430	2.430	2.430	2.485	2.489	2.487	6%	9%	15%
60-64	2.870	2.870	2.870	3.296	3.120	3.194	6%	9%	15%
65+	3.000	3.000	3.000	3.523	2.862	3.193	0%	0%	0%
Average	1.674	1.720	1.700	1.550	1.906	1.750	44%	56%	100%

** Used distribution information from HHS's HEALTH INSURANCE MARKETPLACE: MARCH ENROLLMENT REPORT (3/11/14)*

4. Under the Paid-to-Allowed Ratio section, I will need to see how the URRT factor was developed.

   This 0.737 Paid-to-Allowed ratio is a member weighted average of each plan's Paid-to-Allowed ratio. The below chart illustrates the plan Paid-to-Allowed ratio, expected member distribution (as a percent) and the member weighted average – which is the 0.737 Paid-to-Allowed ratio in the URRT.

2015 IEX Plan	Member Distribution	Paid-to-Allowed
Gold Compass 1250	20.0%	0.819
Silver Compass 2000	15.0%	0.741
Silver Compass 3500-1	15.0%	0.748
Silver Compass 5000	15.0%	0.749
Bronze Compass 5500	10.0%	0.677
Silver Compass HSA 2600	15.0%	0.720
Bronze Compass HSA 4900	10.0%	0.614
	100.0%	**0.737**

5. Within the risk adjustment section, please explain why you think there would be no risk adjustment. The current carriers have absorbed most of the ICHIA and Medicaid Spend Down population and would likely receive a risk adjustment.

   We have priced our individual product based on an affiliated small group carrier, and their data already included any anticipated adjustment for risk adjustment. Therefore, our data already reflects the anticipated market average, so no risk adjustment is expected.

   We also do not anticipate the current distribution of ICHIA and Medicaid Spend Down population to remain static in 2015. As we have a rather broad network, it is projected that we will attract a number of members from this population.

6. You indicate that the reinsurance recoveries are expected to be 7.9% of incurred claims. In the URRT, you show $25.89 for reinsurance adjustment. Please reconcile these values.

   The below chart reconciles the 7.9% reinsurance (of incurred claims) to the $25.89 reinsurance adjustment. Please note: the reinsurance adjustment includes the expected reinsurance fee and the reinsurance recoveries.

Reinsurance Recoveries	7.9%	
Incurred Claims	$ 374.15	
Expected Recoveries	$ 29.56	$29.56 = 7.9% * $374.15
Reinsurance Fees	$ (3.67)	
Total	**$ 25.89**	**$25.89 = $29.56 + -$3.67**

7. In the Profit & Risk Margin, you show reinsurance recoveries of 6.7%, how is this determined?

   The 6.7% reinsurance recoveries noted in the Profit & Risk Margin section is a percent of premium. The 7.9% (noted previously) is a percent of claims. The below chart illustrates how to convert the 7.9% to the 6.7%.

Reinsurance Recoveries	7.9%	
Incurred Claims	$ 374.15	
Expected Recoveries	$ 29.56	$29.56 = 7.9% * $374.15
Average Premium	$ 441.22	
Reinsurance as a Percent of Premium	**6.7%**	**6.7% = $29.56 / $441.22**

   Likewise, one could also multiply the 7.9% reinsurance by the pure loss ratio (claims divided by premium) to calculate the 6.7% reinsurance recoveries (7.9% * 84.8% = 6.7%).

8. In the Profit & Risk Margin, the Insurer Fees are 2.1%, how did you come up with this?

   The 2.1% Insurer Fee calculation is detailed below.

   Total 2014 Insurer Fee = $8B
   Total 2015 Insurer Fee = $11.3B
   2014 to 2015 Percent Increase of Insurer Fee = ($11.3/$8 - 1) = 41.25%
   2014 to 2015 Percent estimated Increase of Industry Premium = 7.81%
   2014 Insurer Fee estimate (before taxes) = 2.5%
   2015 Insurer Fee estimate (before taxes) = (2.5% * (1.4125 /1.0781)) = 3.27%
   2015 Insurer Fee estimate (after taxes) = (3.27% * (1 – 35%)) = **2.13%**

9. In the Profit & Risk Margin, the Exchange Fee should be spread across off-exchange products also. Even though this is an On-Exchange product, it must be available off exchange. Did you take this under consideration?

   Yes, we took this into consideration. We do not expect to sell a significant amount of off-exchange product, so we used the 3.5% assumption.

10. In the Profit & Risk Margin, the Quality Improvement is at .9%. This seems rather high when comparing to the most recent Supplemental Health Care Exhibit, can you explain?

    Please note the below chart – the summation of which adds up to 0.9% entered for Quality Improvement.

Administrative Services	**% of Prem**	**Commentary**
Clinical Programs & Services	0.56%	Multiple clinical programs and services that achieve Wellness & Health Promotion to Improving Health Care Quality.
Clinical Coverage Review	0.14%	Activities to prevent avoidable hospital admissions and to identify and encourage evidence based medicine.
Clinical Care Management	0.08%	Patient centered intervention that assists providers to use best clinical practices to Improve Patient Safety and Reduce Medical Errors.
Customer Education	0.04%	Education programs, participation in self-management programs, and health promotion activities designed to change member behavior (e.g., smoking, obesity).
Provider Education	0.04%	Providing coaching or other support to encourage compliance with evidence based medicine
Pharmacy Clinical Services	0.03%	Prescription drug utilization review to Improve Health Outcomes and Improve Patient Safety and Reduce Medical Errors.
Total	**0.90%**	

11. In the Profit & Risk Margin, the SG&A factor is 6.0%, please split this among the pieces with documentation?

    The below chart illustrates the breakdown of the SG&A factor of 6.04% into its component parts. Please note the percentages shown are a percent of premium.

Account	Percent
Back Office Services - Claims, Customer Service, and IT	3.56%
Salaries	1.08%
Medical Management	0.06%
Licensing & Commissions	0.05%
ID Cards and Mail Services	0.03%
Credit Card Fees	1.25%
Total	**6.04%**

12. Under the Index Rate calculation, of the three benefits you indicate above EHB, we think that only the routine foot care for diabetics would be above EHB.

    We have updated our rate filing information to reflect only routine foot care for diabetics being above EHB.

13. Under market adjusted Index rate, you have exchange user fees of $15.44, please show how this is derived.

    The Exchange Fee as a percent of premium (3.5%) is multiplied by premium (441.22) to calculate the Exchange User Fees. Note the table below for the calculation.

Exchange Fee - Percent of Premium	3.50%	
Average Premium	$ 441.22	
Exchange Fee	**$ 15.44**	**$15.44 = 3.5% * $441.22**

14. You show an example of a single plan adjusted index rate, please provide a table that goes through the pieces for all plans.

    The below chart illustrates the calculation of the Average Premium, beginning with the Market Adjusted Index Rate.

Market Adjusted Index rate		$493.10
Benefits in addition to EHB	+	$0.76
		$493.87
Paid to Allowed Average Factor	x	0.737
		$363.78
Distribution and Admin (Incl.Fees & Costs)	+	$77.43
Average Premium		$441.22

Average Premium is then adjusted at the plan level – this adjustment is Pricing AV of the plan divided by the Average Pricing AV (labeled 'AV / Avg' in the below chart). The below chart illustrates the final Plan Adjusted Index Rate (PAIR) for each plan starting with Average Premium.

Plan Name	*Exp Mem*	*Avg Prm*	*Pricing AV*	*AV / Avg*	*PAIR*
Gold Compass 1250	20.0%	$441.22	1.1370	1.112	$490.70
Silver Compass 2000	15.0%	$441.22	1.0280	1.006	$443.66
Silver Compass 3500-1	15.0%	$441.22	1.0380	1.015	$447.97
Silver Compass 5000	15.0%	$441.22	1.0390	1.016	$448.40
Bronze Compass 5500	10.0%	$441.22	0.9400	0.919	$405.68
Silver Compass HSA 2600	15.0%	$441.22	1.0000	0.978	$431.57
Bronze Compass HSA 4900	10.0%	$441.22	0.8520	0.833	$367.70
Total	**100.0%**	**$441.22**	**1.0224**		**$441.22**

**Figures may not tally due to rounding of display in the exhibit.*

15. In your age curve calibration, you have a value of 1.44 which just happens to be equal to age 45. Please show how this was calculated. In using the age calibration factor, you should use what is calculated and not the rounded age value.

    Early enrollment data for this product illustrated the average age to be 45. At this time, we do not have better information to rely on and priced this product based on an average age of 45.

16. Please show how the .7402 geographic factor was determined.

    The region factor was calculated using the filed region factors and the 2010 Census information for the state of Indiana. The Census information was compiled at the county level and then grouped into the defined 17 rating regions. The below chart illustrates the breakdown of the Census information at the region level and the filed region factors – this information is combined to calculate the filed average region factor of 0.7402.

Area	2010 Census	Factor
Area 1	771,815	0.827
Area 2	612,262	0.704
Area 3	326,399	0.690
Area 4	355,329	0.690
Area 5	89,727	0.710
Area 6	192,859	0.724
Area 7	335,422	0.723
Area 8	247,922	0.745
Area 9	189,764	0.786
Area 10	1,493,380	0.786
Area 11	351,810	0.760
Area 12	190,827	0.689
Area 13	360,579	0.717
Area 14	118,693	0.787
Area 15	228,451	0.670
Area 16	319,758	0.574
Area 17	298,805	0.731
Total	**6,483,802**	**0.7402**

17. With the tobacco adjustment of 1.007, I need to see the expected distribution with a demonstration of how this was determined.

    The tobacco adjustment was calculated using an affiliated carrier's tobacco member months and the applicable tobacco factors (filed in the IN On-Exchange Ratebook). This value (12.3%) was multiplied by the expected Indiana Exchange tobacco member percentage (5.8%) to calculate the 0.7% estimated average adjustment. The below chart illustrates this calculation.

a. Average Tobacco Adjustment	12.3%	
b. Assumed Tobacco Users	5.8%	
c. Total Impact of Tobacco Adjustment	0.7%	(a x b)

18. With the geographic rating areas, please provide some discussion as to why the premium in rating area 1 is 44% above rating area 16 as this is a wider range than I would expect.

    The geographic area factors were developed by our affiliated small group carrier.

19. Your Other medical and Drug PMPM are much lower than average in the URRT. Can you please verify that these are correct?

    The PMPM information on the URRT came from an affiliated small group carrier's experience and adjusted for network, demographic, trend and other differences. The values in the URRT are verified and correct.

Additional Note

In addition to the above responses, we are also proposing an update to our initially submitted starting base rate. Further consideration was given to our morbidity load variation above the affiliated small group carrier. It was determined that our initial assumptions on the impact of transitional relief on the risk pool may have been a bit conservative, and we are therefore recommending modifying our morbidity load from 1.15 to 1.10. This change, which results in a lower base rate, has been included in the updated documents included in the SERFF amendment.

Also, it should be noted that the plan SCID numbers have been updated in the documents as well, since it was discovered after the initial submission that the original SCID naming did not match the company's standard naming convention.

If you have any questions about this filing, please call me at (920) 661-1071 or e-mail me at jshallow@unitedhealthone.com.

Sincerely,



James M Shallow, ASA, MAAA
Associate Director, Actuarial Services

All Savers

June 19, 2014

Kim Isles
Indiana State Department of Insurance
Company Services Division
311 W. Washington Street, Suite 300
Indianapolis, IN 46204-2787

Subject: All Savers Insurance Company
NAIC Company No.: 82406
Resubmission of IEXPOL.I.15.IN - In response to your June 4, 2014 14 item Objection Letter
SERFF Tracking No: UHLC-129514067

Dear Ms. Isles:

1. We have added the Time Limit on Certain Defenses provision, as requested. Please refer to page 55 of the policy document.

2. Federal regulation 45 CFR 147.136 sets forth internal appeals requirements for health insurance issuers with non-grandfathered health plans. Subsection (b)(3)(ii)(G) of federal regulation 45 CFR 147.136 specifically provides that "a health insurance issuer offering *individual health insurance coverage* must provide for only one level of internal appeal before issuing a final determination." [italics added]

   Ind. Code §§ 27-8-28-16 provides for the investigation and review of any grievance submitted by a covered person. Upon the completion of the grievance review, the insurer will notify the covered person of the grievance decision. If the covered person is dissatisfied with the insurer's grievance decision, Ind. Code §§ 27-8-28-17 provides that the covered person may appeal the grievance decision and the insurer will have a panel of one or more qualified individuals review the grievance a second time.

   It appears that Indiana law requires insurers with health insurance plans in the individual market to provide two levels of appeal for the same grievance. Labeling the first level of review a grievance and the second level of review an appeal does not change the fact that the same issue is being examined in both the grievance level of review and the appeal level of review, and that the appeal level of review occurs after the completion of the grievance level of review. It's unclear how a change in the name of a review level could prevent the application of the federal regulation.

   If Golden Rule was required by Indiana law to have two internal appeals levels of review, then there would be a conflict with federal law, essentially preventing the federal regulations from having any effect. We believe that we must follow federal regulations in this situation because any state law which prevents the application of the federal internal appeals requirements is likely preempted by the federal Patient Protection and Affordable Care Act.

3. As requested, we have revised the Free Look Period to be 30 days in accordance with IC 27-8-5-20.

4. In accordance with Indiana law, we have added language detailing the requirements to add a child adopted by the policyholder or the policyholder's spouse to the plan. Please refer to page 49 of the policy, under the subsection Adding New Dependents.

5. We have added language detailing the requirements to add a newborn child of the policyholder or policyholder's spouse to the plan. Please refer to page 49 of the policy, under the subsection Adding New Dependents.

6. Please refer to Cancer Chemotherapy, page 36 and Therapeutic Treatments – Outpatient, page 24.

7. We are unsure of which language you may be taking exception to, however, Bulletin 103 is specifically directed to insurance companies offering group health insurance in Indiana. To our knowledge there is no language contained in the policy which purports to give us full and final disclosure in the manner applicable to ERISA group coverage. Such clauses are only used with ERISA plans, as courts will not give deference to a carrier's discretion to interpret health insurance plan contract provisions in the individual market. Instead the appellate court will always review the determination *de novo* and overturn the plan administrator's decision if it is incorrect. As such, a department of insurance limitation of discretionary clauses is unnecessary in a non-ERISA context, because in an individual health insurance contract, the clause itself will not impact the standard of judicial review.

8. We have revised the Autism Spectrum Disorders Medical Services on page 25 of the policy to address the requirements of Bulletin 136. Unless specifically stated otherwise, benefits for all Covered Health Services under the policy are subject to the deductibles and coinsurance applicable to Sickness generally and are not subject to any lifetime or annual limits. To include this statement in only one benefit provision would give the incorrect impression that this would not apply to other benefit provisions of the policy.

9. The exceptions to Guaranteed Renewability contained in the policy provision are permitted under 45 CFR 147.106(b), items (1), (2) and (4) respectively. However, in order to address your concerns, we have revised the language included on the face page to more closely mirror the language contained in the statute.

   In addition, we have removed reimbursement of premiums from a third party as reason to terminate coverage under the Other Events Ending Your Coverage subsection.

   Under 45 CFR Part 156, the DEPARTMENT OF HEALTH AND HUMAN SERVICES, specifically states, "Our new standard does not prevent QHPs and SADPs from having contractual prohibitions on accepting payments of premium and cost sharing from third party payers other than those specified in this interim final regulation. In particular, as stated in our November FAQ, we remain concerned that third party payments of premium and cost sharing provided by hospitals, other healthcare providers, and other commercial entities could skew the insurance risk pool and create an unlevel competitive field in the insurance market. We continue to discourage such third party payments of premiums and cost sharing, and we encourage QHPs and SADPs to

reject these payments."
CMS encouraged QHP issuers not to accept third party payments from hospitals, other healthcare providers and other commercial entities due to concerns that such practices could skew the insurance risk pool and create an unlevel field in the Exchanges. The language contained under the Premiums provisions is clarifying that we will not accept premium from any Third Party, except as specifically required by law, including the Ryan White HIV/AIDS Program and Indian tribes, tribal organizations or urban Indian organizations.

10. We have added the Refund of Premium Upon Death of Policyholder provision to the Off-Exchange amendment, as requested. Please refer to page 3 of the amendment.

11. A Reinstatement provision serves no purpose when issuance of coverage is guaranteed and is limited to open enrollment and special enrollment periods. As written, IC 27-8-5-3(a)(4) can not be tracked, as it calls for insurer underwriting and approval of the insured's application for reinstatement, which are not permitted post-PPACA.

12. We have revised the Off-Exchange Rider Amendment to reflect that, when adding a dependent, premiums shall be pro-rated from the effective date of coverage.

13. The EHB categories included in the small group forms are included in these individual forms with the exception of Biologically Based Mental Illness, Chiropractic Treatment, Hearing Aids, Obesity Surgery – Morbid Obesity and Voluntary Sterilization Procedures. Biologically –based mental illnesses are payable the same as any other mental illness without limitation under the individual plans. Chiropractic care would be covered under the individual policy under the subsection titled Rehabilitation Services – Outpatient Therapy and Manipulative Treatment. Coverage of Hearing Aids, Morbid Obesity and Voluntary Sterilization Procedures are not included in the individual plan.

    As previously discussed, benefit language that is identical to the language contained in the small group forms has been highlighted in yellow. While I believe that the benefits paid under the small group and the individual plans are the same, there are differences in the language of the Clinical Trials and the Preventive Care Benefits. As you can see, the language for the following EHBs is significantly different, primarily because our parent company, UnitedHealthcare has updated their template languasge: Mental Health Services, Neurodevelopmental Disorders - Autism Spectrum Disorder Services, Substance-Related and Addictive Disorders Services, and Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder.

14. There is only the one policy form, and therefore the benefits of the plans are the same with the exception of cost-sharing differences that are reflected on the Schedules of Benefits.

Sincerely,

Debra Paris

Debra Paris
Manager
Policy Compliance

All Savers Insurance Company

Choice Individual Medical Policy

7440 Woodland Drive
Indianapolis, Indiana 46278-1719
[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX] **Premium Mode** - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if: (A) we do not receive premiums when due, as described in the Policy; (B) a Covered Person has committed an act of fraud or made an intentional misrepresentation in connection with the Policy; (C) we discontinue offering and~~However, we may refuse renewal if we~~ refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live; or (D) we discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside. Please refer to Events Ending Your Coverage for further information~~, or there is fraud or a material misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits~~.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

3010~~10~~-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 3010 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

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This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, if any, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

- The study or investigation is conducted 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 clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits will also be provided for re-education or refresher training.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipmen*t. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug* subsection.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

5. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

11. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorder that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.

- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

13. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

14. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

15. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

16. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

17. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on

how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

18. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

19. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

20. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

21. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

23. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

24. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

25. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), chemotherapy (whether administered orally, intravenously, or by injection) or other intravenous infusion therapy and radiation oncology.

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

26. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

27. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

28. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

29. Autism Spectrum Disorder Medical Services

Benefits are provided on the same basis as any other Sickness for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by a treating Physician for the treatment of Autism Spectrum Disorder. Any exclusion within the Policy that is inconsistent with the treatment plan will not apply.

Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

30 Cancer Chemotherapy

Covered Health Services include chemotherapy for the treatment of cancer, whether administered orally, intravenously or by injection.

31. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by ~~implant,~~ dentures or bridges.

3231. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

3332. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

3433. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

3534. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

3635. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

3736. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription

Drugs This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health

management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly associated with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA)*

Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).

- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.

- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
    - Extraction, restoration and replacement of teeth.
    - Medical or surgical treatments of dental conditions.
    - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
    - Blood pressure cuff/monitor.
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

- The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
- The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.
18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.
19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
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 may be made up to six times during a calendar

year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.
25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
28. A Prescription Drug Product that contains marijuana, including medical marijuana.
29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.
30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:

- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Neurodevelopmental Disorders - Autism Spectrum Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

7. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.

- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.

- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
15. In vitro fertilization regardless of the reason for treatment.

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 residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Fetal reduction surgery.
6. Abortion, except for Therapeutic Abortion.

P. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Q. Substance-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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

R. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

S. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.

3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:
    - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - Related to judicial or administrative proceedings or orders.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
    - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion

does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Subject to a determination of the Indiana Health Insurance Exchange, a newborn child of the Policyholder or the Policyholder's spouse will be covered from the time of birth until the 31st day after birth. Coverage will terminate on the 31st day following birth, unless we have received notice of the child's birth and any additional premium required. Coverage of the newborn child shall include coverage of Sickness and Injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including intpatient and outpatient expenses arising from medical and dental treatment involved in the management of cleft lip and cleft palate.

Subject to a determination of the Indiana Health Insurance Exchange, a child placed for adoption with the Policyholder or the Policyholder's spouse will be covered from the date of Placement until the 31st day following Placement unless the Placement is disrupted prior to legal adoption and the child is removed from the insured's custody. Coverage will terminate on the 31st day following Placement, unless we have received notice of the intent to adopt the child and any additional premium required.

"Placement" when used in reference to an adoption, means the earlier of:

- The date of placement for the purpose of adoption.
- The date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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.

- ~~**You Accept Reimbursement for Premium**~~

  ~~You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:~~

  - ~~Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.~~
  - ~~Indian tribes, tribal organizations or urban Indian organizations~~
  - ~~State and Federal Government programs.~~

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Time Limit on Certain Defenses

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent mistatements, made in the application for coverage shall be used to void the Policy or deny a claim for loss incurred after the expiration of this two year period.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Assistance

A toll free telephone number is available for a Covered Individual to obtain information about filing Grievances.

- The individuals that answer the toll free telephone number can assist the caller or forward the call to the appropriate department if additional information is needed.
- Calls can be received at least 40 normal business hours per week and at other times the calls will be recorded by voicemail.
- If a call is left on voicemail, a qualified individual will respond to the call the next business day after the call is received.
- The calls will be answered by individuals who speak the English language. Non-English languages will be translated through a third party translation service.

Assistance is also available for Covered Individuals with literacy, physical, health, or other impediments.

Initial Utilization Review Determinations

Within 2 business days after receiving a request for a Utilization Review Determination that includes all information necessary to complete the Utilization Review Determination, we or a Utilization Review agent acting on our behalf, will notify the Covered Individual of the Utilization Review Determination by mail or another means of communication.

If the Utilization Review Determination does not certify an admission, a service, or a procedure, the notice will include:

- If the Utilization Review Determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination;
- The procedures to file a Grievance; and
- The toll free telephone number that the Covered Individual may call to request a review of the determination or obtain further information about the right to file a Grievance.

Internal Review of Grievances

Non-Urgent Care Review Request: A Covered Individual has 180 days following receipt of an initial notification of a determination to file a Grievance orally or in writing.

Urgent Care Review Request: Expedited reviews are available for Grievances regarding urgent care.

- **Acknowledgement:** An acknowledgement of the Grievance, given orally or in writing, must be provided by us within 5 business days after receipt of the Grievance. The notice must include:
- The name, address, and telephone number of an individual to contact regarding the Grievance; and
- The date the Grievance was filed.

Reviewer's Requirements:

- All Grievances regarding urgent care will be reviewed by a physician.
- A Grievance regarding appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a panel of one or more qualified individuals appointed by us.

- The panel must include one or more individuals who:
  - Have knowledge of the medical condition, procedure, or treatment at issue;
  - Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment or service;
  - Were not involved in the original determination; and
  - Do not have a direct business relationship with the Covered Individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.
- The Covered Individual will be given the opportunity to appear in person before the panel or if unable to appear in person, otherwise appropriately communicate with the panel. The Covered Individual will be notified not less than 72 hours prior to the meeting of the panel.
- The panel will meet during normal business hours and at a place convenient to a Covered Individual who wishes to appear before or otherwise communicate with the panel.

- All other Grievances that are based in whole or in part on a medical judgment will be reviewed by a health care professional who has appropriate expertise in the field of medicine involved in the medical issue, was not involved in the original determination, and is not the subordinate of the original reviewer.
- If the Grievance concerns a Rescission action, a panel of individuals who were not involved in the original determination and who are not the subordinates of the original reviewer will review the Grievance.
- All other Grievances will be reviewed by an impartial person who was not involved in making the original determination, is not the subordinate of the original reviewer, and has sufficient experience, knowledge, and training to appropriately resolve the Grievance.

General Information:

- Covered Individuals have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
- Covered Individuals have the right to review the claim file and to present evidence and testimony as part of the internal review process.
- Covered Individuals may request reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge.
- All comments, documents, records and other information submitted by the Covered Individual relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial benefit determination, will be considered in the internal Grievance review.
- The Covered Individual will receive from us, as soon as possible, any new or additional evidence considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new information.
- The Covered Individual will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

- A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.
- The internal appeal process must be exhausted before the Covered Individual may request an external review, unless:
  - The plan provides a waiver of this requirement;
  - The plan fails to follow the appeal process; or
  - The Covered Individual files an urgent care external appeal at the same time as an urgent care internal appeal.
- Resolution Timeframe:
- A Grievance regarding non-urgent care must be resolved as expeditiously as possible, reflecting the clinical urgency of the situation, but no later than:
  - 45 days after the Grievance regarding Post-service Claims is filed; or
  - 30 days after the Grievance regarding Pre-service Claims is filed.
- We will first orally notify the Covered Individual of the Grievance decision regarding urgent care within:
  - 48 hours after the Grievance regarding a Utilization Review Determination is filed and all the information necessary to complete the review is received, or 72 hours after the Grievance is received, whichever is earlier; or
  - 72 hours for all Grievances that are not regarding Utilization Review Determinations.
- The oral notification will be followed by a written notice as described in the Notification of Determination provision below.

Notification of Determination: We will notify a Covered Individual in writing of the resolution of the Grievance immediately for Grievances regarding Pre-service Claims or within 5 business days after completing an investigation of a Grievance regarding Post-service Claims. The notice must include:

- A statement of our understanding of the Covered Individual's Grievance;
- The decision reached by us;
- The contractual basis for the decision, including reference to specific plan provisions on which the determination is made;
- If applicable, the medical rationale for the resolution stated in sufficient detail for the Covered Individual to respond further to our position;
- Reference to the evidence or documentation used as the basis for the resolution, including a statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Individual's claim for benefits;
- The specific reason or reasons for the determination;
- A statement that the Covered Individual may have a right to bring a civil action under state or federal law;
- The specific rule, guideline, protocol, or other similar criterion, if used to make the determination, or that it will be provided free of charge upon request;
- The date of service;
- The health care provider's name;

- The claim amount;
- The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
- Our denial code with corresponding meaning;
- A description of any standard used, if any, in denying the claim;
- The department, address, and telephone number through which a Covered Individual may contact a qualified representative to obtain additional information about the decision or the next level of appeal available to them;
- If the Grievance is regarding appropriateness, medical necessity, experimental or investigational treatment or a Rescission:
    - Notice of the Covered Individual's right to external review by an independent review organization (IRO), including a description of the external review procedure; and
    - A copy of the Indiana Authorization Form which authorizes us to disclose protected health information for the external review; and
    - The plan must provide for the identification of medical experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the determination; and
- If applicable:
    - That assistance is available by contacting the specific state's consumer assistance department; and
    - A culturally linguistic statement based upon the Covered Individual's county or state of residence that provides for oral translation of the determination.

External Review

Non-Expedited Request:

- After exhausting the internal Grievance process, a Covered Individual has 120 days after notice of the second-level review resolution to request an external review in writing. A request for external review may only be made for a Grievance regarding:
    - A determination that a service or proposed service it not appropriate or Medically Necessary;
    - A determination that a service or proposed service is experimental or investigational; or
    - Our decision to Rescind an accident and sickness insurance policy.
- The Covered Individual is permitted to submit additional information regarding the proposed service throughout the external review process.
- The Covered Individual must sign an authorization form to release necessary medical information.

Expedited Request: An expedited request maybe made for Grievances related to a Sickness, disease, condition, Injury, or disability if the time frame for a standard review would seriously jeopardize the Covered Individual's:

- Life or health; or
- Ability to reach and maintain maximum function.

Procedure:

- When a request for external review is filed, we will:

- Select an IRO from a list of IROs that are certified by the Department of Insurance (DOI); and
- Rotate the choice of an IRO among all certified IROs before repeating a selection.

- We will cooperate with the IRO by promptly providing the IRO with any information requested by the IRO.
- If, at any time during an external review, the Covered Individual submits information to us that is relevant to our resolution and was not previously considered, we may reconsider the previous resolution.
  - The IRO will cease the external review process until the reconsideration is completed.
  - We will notify the Covered Individual of the decision within 15 business days after the information is submitted (72 hours for an expedited review).
  - If our decision is adverse to the Covered Individual, the Covered Individual may request that the IRO resume the external review.
- If we choose not to reconsider, we will forward the submitted information to the IRO within 2 business days after receipt.

Resolution Timeframe and Notification of Determination:

- The IRO will make a determination to uphold or reverse our determination within 15 business days (3 business days for expedited) after the request for external review is filed. The IRO will base their determination on information gathered from the Covered Individual or the Covered Individual's designee, us, and the treating health care provider, and any additional information that the IRO considers necessary and appropriate.
- The IRO will notify us and the Covered Individual of their determination within 72 hours (24 hours for expedited) of making the determination.

General Information:

- An external review decision is binding on us.
- We will pay for all costs of the external review by the IRO.

Definitions

As used in this section, the following terms have the meanings indicated.

Authorized Representative means:

- A person to whom a Covered Individual has given express written consent to represent the Covered Individual;
- A person authorized by law to provide substituted consent for a Covered Individual; or
- A family member of the Covered Individual or the Covered Individual's treating health care professional when the Covered Individual is unable to provide consent.

For purposes of these procedures, a reference to a Covered Individual may also refer to an Authorized Representative.

Covered Individual means an individual who is covered under an accident and sickness insurance policy. For purposes of these procedures, and where applicable, a Covered Individual may also include:

- An Authorized Representative of the Covered Individual; and
- A Provider Of Record acting on behalf of the Covered Individual.

Grievance means any dissatisfaction expressed by or on behalf of a Covered Individual regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is experimental or investigational;
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between:
  - A Covered Individual and us; or
  - A group policyholder and us; or
- Our decision to Rescind an accident and sickness insurance policy;

and for which the Covered Individual has a reasonable expectation that action will be taken to resolve or reconsider the matter than is the subject of dissatisfaction.

Notification Involving Urgent Care means a Grievance that meets any of the following conditions:

- The time periods for making non-urgent care review recommendations:
  - Could seriously jeopardize the life or health of the Covered Individual or the ability of the Covered Individual to regain maximum function; or
  - In the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
- Other than above, the decision as to whether a condition involves urgent care is to be determined by the attending provider, and we must defer to such determination of the attending provider.

Pre-service Claim means any claim for benefits for medical care or treatment that requires our approval in advance of the Covered Individual obtaining the medical care.

Provider Of Record means the physician or other licensed practitioner identified to a Utilization Review agent as having primary responsibility for the care, treatment, and services rendered to a Covered Individual.

Post-service Claim means any claim for benefits for medical care or treatment that is not a Pre-service Claim.

Rescind or **Rescission** means a cancellation or discontinuance of coverage by us that has a retroactive effect.

Utilization Review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a Covered Individual. The term does not include:

- Elective requests for clarification of coverage, eligibility, or benefits verification; or
- Medical claims review.

Utilization Review Determination means the rendering of a decision based on Utilization Review that denies or affirms either of the following:

- The necessity or appropriateness of the allocation of resources; or
- The provision or proposed provision of health care services to a Covered Individual.

The term does not include the identification of alternative, optional medical care that requires the approval of the Covered Individual and does not affect coverage or benefits if rejected by the Covered Individual.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive authority to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, as we determine, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

Individual Off-Exchange Qualified Health Plan Policy Amendment

All Savers Insurance Company

As described in this Amendment, the Qualified Health Plan Policy is modified to support coverage for Eligible Persons who wish to purchase the same Qualified Health Plan coverage off the individual exchange.

1. *Section 3: When Coverage Begins and Premiums* is replaced in its entirety with the following:

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete and submit an application for insurance and make the required Premium payment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

Who is eligible to enroll and who qualifies as a Dependent will be determined by us under the terms of this Policy.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules for coverage under this Policy and as determined based on information submitted in the application for coverage. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can apply for insurance for themselves and their Dependents, as determined by state or federal law.

Coverage begins on the date identified in this Policy if we receive the completed application and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by state or federal law.

Adding New Dependents

Policyholders may apply for insurance for Dependents only as described below.

The Policyholder must notify us of a new Dependent to be added to this Policy. Additional Premium may also be required, and it will be calculated from the date coverage is effective.

Dependent Eligibility

Your Dependents become eligible for insurance on the later of following:

- The date you became insured under this Policy.
- The first day of the first full calendar month after the date of becoming your Dependent.

Effective Date for Initial Dependents:

The effective date for your initial Dependents, if any, is shown on the face page of the Policy. Only Dependents included in the application for insurance will be covered on your effective date.

Adding a Newborn Child:

A Dependent child born to you or your spouse will be covered from the time of birth until the 31st day after birth, unless you or your spouse advises us not to add the newborn child.

Adding an Adopted Child:

A Dependent child legally placed for adoption with you or your spouse will be covered from the date of placement until the 31st day after placement, unless the placement is disrupted prior to legal adoption and the child is removed from your or your spouse's custody.

As used in this provision, "placement" means the earlier of the following:

- The date that you or your spouse assume physical custody of the child for the purpose of adoption.
- The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.

Additional Premium:

Additional Premium may be required to continue coverage beyond the 31st day following the birth or placement of the child. The required Premium will be calculated from the date of birth or date of placement for adoption. Coverage of the child will terminate on the 31st day following birth or placement,

unless we have received both written notice of the child's birth or your or your spouse's intent to adopt the child and the required premium within 90 days of the date of birth or date of placement.

Adding Other Dependents:

If you submit an application for insurance on a Dependent and you pay the required Premiums, then the effective date will be shown in the written notice to you that the Dependent is insured.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

When adding a Dependent, Premiums shall be pro-rated based upon the effective date of the Dependent's coverage.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify us of your new residence. Your Premium will be based on your new residence beginning on the date determined by us. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

2. *Section 4: When Coverage Ends* is replaced in its entirety with the following:

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date we terminate as a Qualified Health Plan Issuer.
  - The date this benefit plan is decertified as a *Qualified Health Plan*.
  - The date we specify that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.

- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date you request if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy.

3. The definition of Eligible Person in *Section 8: Defined Terms* is replaced with the following:

Eligible Person - a person who meets the eligibility requirements for coverage under this Policy and as determined based on information submitted in the application. An Eligible Person must live within the Service Area.

_____

(Name and Title)

Indiana Small Employer Group Rate Filing

Actuarial Memorandum V3

UnitedHealthcare Insurance Company

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Provide an attestation along with documentation confirming the following:
i. Review of Indiana's small group health law. (Ind. Code §27-8-15)
ii. Compliance with Indiana's small group health law. (Ind. Code §27-8-15)
iii. Intent to file annual actuarial certification. (Ind. Code §27-8-15)
Section 9 Actuarial Certification/Rate Attestation 14
Provide an actuarial certification with a clear statement attesting to the following:
i. Compliance with all applicable state and federal statutes and regulations.
ii. Compliance with actuarial standards of practice (ASOP).

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Section 1 Benefit Structure

a. Scope and Purpose of Filing Statement

The purpose of this rate filing is to provide relevant actuarial information regarding the development of premium rates for small employer group insurance sold by UnitedHealthcare Insurance Company (UnitedHealthcare). The rates are applicable for medical (including prescription drug (Rx)) expense benefits for employers with 2 to 50 eligible employees (small employer groups) for the state of Indiana.

- Effective 1/1/2014, we will introduce 74 new plans which will be called our *2014 ACR* plan portfolio.

This rate filing is not intended to be used for any other purpose than what is stated here.

b. Market Impacted

This rate filing is for small employer group insurance sold by UnitedHealthcare Insurance Company (UnitedHealthcare)

c. Benefit Summary

Essential Health Benefits – All plans include the required Essential Health Benefits as posted on IN.gov and included in form filings –

EBA.AMD.I.11.IN.NGF.SB – Essential Health Benefits Amendment
RID.PDS.NET.I.11.IN.NGF.SB – Pediatric Dental Rider (Network only)
RID.PDS.NET-NON.I.11.IN.NGF.SB – Pediatric Dental Rider (Network and Non-Network)
RID.PVC.NET.I.11.IN.NGF.SB – Pediatric Vision Rider (Network only)
RID.PVCS.NET-NON.I.11.NGF.SB– Pediatric Vision Rider (Network and Non-Network)

State Mandated Benefits – All plans include the required State Mandated Benefits as listed in the Small Group Checklist 20A

IC 27-8-5-15.6(e)	Mental Health Parity, IF mental health benefits offered; Substance abuse parity with mental health parity offered
IC 27-8-5-21	Adopted children
IC 27-8-5-26	Breast reconstruction & prosthesis
IC 27-8-5-27	Dental anesthesia/ hospitalization
IC 27-8-5-28 Bulletin 189	Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26.
IC 27-8-5-21	Adopted children

IC 27-8-5-26	Breast reconstruction & prosthesis
IC 27-8-5-27	Dental anesthesia/ hospitalization
IC 27-8-14.5	Diabetes treatment, supplies, equipment & education
IC 27-8-14.7	Prostate cancer screening
IC 27-8-14.8	Colorectal cancer screening
IC 27-8-24-4	Minimum postpartum stay and infant screening tests required by IC 16-41
IC 27-8-24.1	Inherited metabolic disease
IC 27-8-24.2-5	Orthotic and prosthetic devices
IC 27-8-24.3	Victims of abuse without regard to the abuse
IC 27-8-26	Individuals without regard to genetic testing
IC 27-8-20	Off-label use of certain drugs
Bulletin 172	Chemotherapy parity
760 IAC 1-39-7	AIDS, HIV and related conditions
IC 27-8-14.1	Coverage for surgical treatment of morbid obesity.

Section 2 Proposed Rates

a. 2014 Q1 Rate Table Sample for Plan HL-D – The entire table of 2014 rates can be found in the IN Rate Table spreadsheet included in this SERFF filing.

First Quarter Rates from Federal Rates Template

Plan ID	Rating Area ID	Tobacco	Age	Individual Rate
HL-D	Rating Area 1	No Preference	0-20	242.54
HL-D	Rating Area 1	No Preference	21	381.95
HL-D	Rating Area 1	No Preference	22	381.95
HL-D	Rating Area 1	No Preference	23	381.95
HL-D	Rating Area 2	No Preference	26	332.95
HL-D	Rating Area 2	No Preference	27	340.75
HL-D	Rating Area 2	No Preference	28	353.43
HL-D	Rating Area 3	No Preference	31	369.35
HL-D	Rating Area 3	No Preference	32	377.00
HL-D	Rating Area 3	No Preference	33	381.78
HL-D	Rating Area 4	No Preference	36	391.97
HL-D	Rating Area 4	No Preference	37	394.52
HL-D	Rating Area 4	No Preference	38	397.07
HL-D	Rating Area 5	No Preference	41	426.95
HL-D	Rating Area 5	No Preference	42	434.49
HL-D	Rating Area 5	No Preference	43	444.98
HL-D	Rating Area 6	No Preference	46	501.57
HL-D	Rating Area 6	No Preference	47	522.64
HL-D	Rating Area 6	No Preference	48	546.71
HL-D	Rating Area 7	No Preference	51	622.76
HL-D	Rating Area 7	No Preference	52	651.81
HL-D	Rating Area 7	No Preference	53	681.20
HL-D	Rating Area 7	No Preference	54	712.92
HL-D	Rating Area 8	No Preference	56	802.74
HL-D	Rating Area 8	No Preference	57	838.52
HL-D	Rating Area 8	No Preference	58	876.72
HL-D	Rating Area 9	No Preference	61	1,020.08
HL-D	Rating Area 9	No Preference	62	1,042.95
HL-D	Rating Area 9	No Preference	63	1,071.63
HL-D	Rating Area 9	No Preference	Over 63	1,089.05
HL-D	Rating Area 10	No Preference	0-20	230.52
HL-D	Rating Area 10	No Preference	21	363.02
HL-D	Rating Area 10	No Preference	22	363.02
HL-D	Rating Area 11	No Preference	26	359.43
HL-D	Rating Area 11	No Preference	27	367.86
HL-D	Rating Area 11	No Preference	28	381.55
HL-D	Rating Area 12	No Preference	31	368.81
HL-D	Rating Area 12	No Preference	32	376.45
HL-D	Rating Area 12	No Preference	33	381.22
HL-D	Rating Area 13	No Preference	36	407.31
HL-D	Rating Area 13	No Preference	37	409.96
HL-D	Rating Area 13	No Preference	38	412.61
HL-D	Rating Area 14	No Preference	41	473.25
HL-D	Rating Area 14	No Preference	42	481.61
HL-D	Rating Area 14	No Preference	43	493.24
HL-D	Rating Area 15	No Preference	46	464.16
HL-D	Rating Area 15	No Preference	47	483.66
HL-D	Rating Area 15	No Preference	48	505.94
HL-D	Rating Area 16	No Preference	21	265.10
HL-D	Rating Area 16	No Preference	22	265.10
HL-D	Rating Area 16	No Preference	23	265.10
HL-D	Rating Area 17	No Preference	56	787.66
HL-D	Rating Area 17	No Preference	57	822.77
HL-D	Rating Area 17	No Preference	58	860.24

b. Factors - all rating factors are included in Section 6

Section 3 Projected Experience with Enrollment Projections

a. Projected Earned Premium and b. Incurred Claims

Plan Code	Projected 2014 Premium	Projected 2014 Incurred Claims	Projected 2014 Member Months	Projected 7/2013 - 6/2014 Premium	Projected 7/2013 - 6/2014 Incurred Claims	Projected 7/2013 - 6/2014 Member Months
HL-D	$1,991,806	$1,807,447	4,632	$995,903	$903,724	2,316
HK-8	$410,564	$333,054	876	$205,282	$166,527	438
HK-9	$6,289,198	$4,908,983	14,280	$3,144,599	$2,454,492	7,140
GE-U	$5,099,862	$4,206,702	12,264	$2,549,931	$2,103,351	6,132
GE-V	$4,237,062	$3,225,977	9,624	$2,118,531	$1,612,989	4,812
HK-7	$11,699,005	$8,891,175	25,356	$5,849,502	$4,445,588	12,678
HG-8	$10,359,850	$8,189,402	23,256	$5,179,925	$4,094,701	11,628
HK-6	$7,536,685	$5,551,287	16,152	$3,768,342	$2,775,644	8,076
HL-E	$15,209,730	$12,540,576	34,824	$7,604,865	$6,270,288	17,412
HL-G	$14,157,659	$10,828,718	30,060	$7,078,829	$5,414,359	15,030
HL-F	$6,672,453	$5,563,034	15,228	$3,336,226	$2,781,517	7,614
HL-H	$5,685,159	$4,560,546	12,900	$2,842,580	$2,280,273	6,450
GP-G	$1,772,073	$1,275,598	4,164	$886,037	$637,799	2,082
FN-9	$6,859,352	$5,434,945	14,868	$3,429,676	$2,717,473	7,434
GO-8	$4,203,328	$3,017,584	8,364	$2,101,664	$1,508,792	4,182
GO-9	$6,868,350	$5,011,101	15,216	$3,434,175	$2,505,551	7,608
GP-D	$2,072,821	$1,544,705	4,788	$1,036,410	$772,353	2,394
GP-E	$2,280,456	$1,724,630	5,436	$1,140,228	$862,315	2,718
GP-F	$1,355,451	$982,848	3,192	$677,725	$491,424	1,596
GP-H	$1,931,267	$1,487,567	3,996	$965,633	$743,784	1,998
GP-I	$10,718,445	$8,590,064	25,692	$5,359,223	$4,295,032	12,846
GP-J	$6,302,317	$4,864,366	14,844	$3,151,159	$2,432,183	7,422
GP-K	$2,723,381	$2,121,062	6,708	$1,361,690	$1,060,531	3,354
GK-W	$3,728,897	$2,883,146	9,312	$1,864,449	$1,441,573	4,656
GK-4	$1,088,988	$802,553	1,692	$544,494	$401,277	846
GK-5	$1,755,273	$1,190,123	2,868	$877,637	$595,062	1,434
GK-6	$1,958,507	$1,422,348	3,396	$979,254	$711,174	1,698
GK-7	$620,716	$471,811	1,176	$310,358	$235,906	588
GK-8	$3,890,672	$2,595,653	6,948	$1,945,336	$1,297,827	3,474
GK-9	$1,745,366	$1,190,577	2,880	$872,683	$595,289	1,440
GK-X	$655,583	$436,779	1,116	$327,792	$218,390	558
GK-Y	$1,403,757	$1,034,933	2,244	$701,878	$517,467	1,122
GK-Z	$1,308,510	$965,607	2,232	$654,255	$482,804	1,116
GL-1	$929,176	$764,658	1,932	$464,588	$382,329	966
GL-2	$1,008,096	$634,521	1,524	$504,048	$317,261	762
GL-3	$1,521,431	$1,021,515	3,036	$760,715	$510,758	1,518
GL-4	$1,839,270	$1,207,570	3,036	$919,635	$603,785	1,518
GL-5	$3,077,286	$2,098,461	5,136	$1,538,643	$1,049,231	2,568
GL-6	$1,769,053	$1,215,091	2,844	$884,527	$607,546	1,422
GL-7	$1,033,267	$745,160	2,076	$516,633	$372,580	1,038
GL-8	$371,665	$279,884	708	$185,832	$139,942	354
GL-9	$1,180,755	$862,247	2,424	$590,377	$431,124	1,212
GL-J	$1,551,336	$849,978	2,808	$775,668	$424,989	1,404
GL-K	$1,104,737	$733,288	2,340	$552,369	$366,644	1,170
GL-L	$4,478,432	$3,041,684	7,956	$2,239,216	$1,520,842	3,978
GL-M	$406,833	$269,231	696	$203,416	$134,616	348
GL-N	$512,376	$347,946	936	$256,188	$173,973	468
GL-O	$1,481,450	$1,001,494	2,664	$740,725	$500,747	1,332
GL-P	$535,269	$321,657	888	$267,634	$160,829	444
GL-Q	$329,000	$164,480	384	$164,500	$82,240	192
GL-R	$3,606,345	$2,592,967	6,516	$1,803,173	$1,296,484	3,258
GL-S	$289,729	$183,060	516	$144,864	$91,530	258
GL-T	$1,219,011	$970,787	2,604	$609,505	$485,394	1,302
GL-U	$1,135,541	$743,082	2,436	$567,771	$371,541	1,218
GL-V	$3,238,273	$2,154,667	5,964	$1,619,137	$1,077,334	2,982
GL-W	$2,100,354	$1,445,739	3,864	$1,050,177	$722,870	1,932
GL-X	$1,076,093	$679,779	1,908	$538,046	$339,890	954
GL-Y	$375,670	$226,802	816	$187,835	$113,401	408

Plan Code	Projected 2014 Premium	Projected 2014 Incurred Claims	Projected 2014 Member Months	Projected 7/2013 - 6/2014 Premium	Projected 7/2013 - 6/2014 Incurred Claims	Projected 7/2013 - 6/2014 Member Months
Code1	$0	$0	0	$0	$0	0
Code2	$0	$0	0	$0	$0	0
Code3	$0	$0	0	$0	$0	0
D1-5	$0	$0	0	$0	$0	0
D1-6	$0	$0	0	$0	$0	0
D2-2	$0	$0	0	$0	$0	0
D2-3	$0	$0	0	$0	$0	0
DY-1	$0	$0	0	$0	$0	0
Code4	$0	$0	0	$0	$0	0
Code5	$0	$0	0	$0	$0	0
Code6	$0	$0	0	$0	$0	0
Code7	$0	$0	0	$0	$0	0
Code8	$0	$0	0	$0	$0	0
Code9	$0	$0	0	$0	$0	0
Code10	$0	$0	0	$0	$0	0
Code11	$0	$0	0	$0	$0	0

At the time of this filing, codes 1-11 have not yet had plan codes assigned.

c. Anticipated Loss Ratios

i. Next 12 Months: 75.6%
ii. Next full calendar year: 75.6%

d. Projected Federal MLR

The projected loss ratio using the federally prescribed MLR methodology is 79%. There is a 1% contingency margin, and when included, the projected loss ratio is 80%. If the actual loss ratio is below the 80% MLR requirement for small business, rebates will be paid as the law requires.

e. Historical Earned Premium, Incurred Claims and Rate Increase information

United Healthcare Insurance Company 2-50 Experience (paid through 7/2013)			
	Indiana (Non-Chicago Only)		
Experience Period	Member Months	Premium	Incurred Claims
2010 Calendar Year	226,718	83,437,770	63,831,592
2011 Calendar Year	295,273	114,904,342	86,528,415
2012 Calendar Year	318,167	132,392,251	95,205,390
	Nationwide		
	Member Months	Premium	Incurred Claims
2010 Calendar Year	15,417,033	5,586,262,672	4,389,734,544
2011 Calendar Year	14,812,762	5,591,273,327	4,118,823,832
2012 Calendar Year	15,630,595	6,104,646,142	4,611,998,734

United Healthcare Insurance Company 2-50 Premium PMPM				
	Indiana (Non-Chicago Only)		Nationwide	
Experience Period	Premium PMPM	% Change	Premium PMPM	% Change
2009	347.95		341.27	
2010	368.02	5.8%	362.34	6.2%
2011	389.15	5.7%	377.46	4.2%
2012	416.11	6.9%	390.56	3.5%

Section 4 Assumptions

a. Annual Overall Trend Rate

i. Annual per individual rate of medical cost increase assumed for the next year.

9.5%

ii. Annual per individual rate of premium increase assumed for the next year.

9.5%

Quarterly Trend - Trended to Mid-Point of Quarter

Quarter	Trend Factor
1/1/2014	1.011
4/1/2014	1.035
7/1/2014	1.058
10/1/2014	1.083

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, benefit leveraging, and business mix identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected net of business mix (employer mix, benefit mix, demographic mix, etc.). Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence mix of procedures.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Business mix changes that influence medical cost trends are also reviewed and projected, with appropriate input from sales and underwriting staff. These factors include changing mix of employer groups, mix of benefits, and demographic changes. For the purposes of developing premium pricing trend projections, the component of trend attributable to business mix is excluded.

Section 5 Premium Guarantee Provision

Rates are guaranteed for 12 months for the initial policy year and also for renewal policy years.

Section 6 Rating Factors

a. Factors

i. Age Factors

Age	Factor	Age	Factor	Age	Factor
Under 21	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	Over 63	3.000

The Child factor is a per child factor up to a maximum number of three children.

ii. Geographic Factors

Rating Area	Area Factor
1	0.8270
2	0.7040
3	0.6900
4	0.6900
5	0.7100
6	0.7240
7	0.7230
8	0.7450
9	0.7860
10	0.7860
11	0.7600
12	0.6890
13	0.7170
14	0.7870
15	0.6700
16	0.5740
17	0.7310

County	Rating Area	Area Factor
ADAMS	3	0.6900
ALLEN	4	0.6900
BARTHOLOMEW	12	0.6890
BENTON	5	0.7100
BLACKFORD	8	0.7450
BOONE	10	0.7860
BROWN	13	0.7170
CARROLL	7	0.7230
CASS	6	0.7240
CLARK	16	0.5740
CLAY	9	0.7860
CLINTON	7	0.7230
CRAWFORD	16	0.5740
DAVIESS	15	0.6700
DE KALB	3	0.6900
DEARBORN	14	0.7870
DECATUR	12	0.6890
DELAWARE	8	0.7450
DUBOIS	15	0.6700
ELKHART	2	0.7040
FAYETTE	11	0.7600
FLOYD	16	0.5740
FOUNTAIN	7	0.7230
FRANKLIN	14	0.7870
FULTON	6	0.7240
GIBSON	17	0.7310
GRANT	8	0.7450
GREENE	15	0.6700
HAMILTON	10	0.7860
HANCOCK	11	0.7600
HARRISON	16	0.5740
HENDRICKS	10	0.7860
HENRY	11	0.7600
HOWARD	6	0.7240
HUNTINGTON	3	0.6900
JACKSON	12	0.6890
JASPER	5	0.7100
JAY	8	0.7450
JEFFERSON	16	0.5740
JENNINGS	12	0.6890
JOHNSON	13	0.7170
KNOX	15	0.6700
KOSCIUSKO	2	0.7040
LA PORTE	1	0.8270
LAGRANGE	3	0.6900
LAKE	1	0.8270

County	Rating Area	Area Factor
LAWRENCE	13	0.7170
MADISON	11	0.7600
MARION	10	0.7860
MARSHALL	2	0.7040
MARTIN	15	0.6700
MIAMI	6	0.7240
MONROE	13	0.7170
MONTGOMERY	7	0.7230
MORGAN	10	0.7860
NEWTON	5	0.7100
NOBLE	3	0.6900
OHIO	14	0.7870
ORANGE	15	0.6700
OWEN	13	0.7170
PARKE	9	0.7860
PERRY	15	0.6700
PIKE	15	0.6700
PORTER	1	0.8270
POSEY	17	0.7310
PULASKI	6	0.7240
PUTNAM	7	0.7230
RANDOLPH	8	0.7450
RIPLEY	14	0.7870
RUSH	12	0.6890
SCOTT	16	0.5740
SHELBY	10	0.7860
SPENCER	15	0.6700
ST JOSEPH	2	0.7040
STARKE	2	0.7040
STEUBEN	3	0.6900
SULLIVAN	9	0.7860
SWITZERLAND	14	0.7870
TIPPECANOE	7	0.7230
TIPTON	7	0.7230
UNION	11	0.7600
VANDERBURGH	17	0.7310
VERMILLION	9	0.7860
VIGO	9	0.7860
WABASH	3	0.6900
WARREN	5	0.7100
WARRICK	17	0.7310
WASHINGTON	16	0.5740
WAYNE	11	0.7600
WELLS	3	0.6900
WHITE	5	0.7100
WHITLEY	3	0.6900

iii. Benefit Plan Factors

Indiana

Medical Plan Code	Product Type	HSA/HRA	Actuarial Value	Metallic Designation	Benefit Relativity
HL-D	EPO		80.1	Gold	0.6003
HK-8	EPO		78.3	Gold	0.5838
HK-9	EPO		71.6	Silver	0.5352
GE-U	EPO		71.9	Silver	0.5327
GE-V	EPO		70.3	Silver	0.5180
HK-7	EPO		71.3	Silver	0.5425
HG-8	EPO		71.7	Silver	0.5439
HK-6	EPO		70.5	Silver	0.5292
FN-9	EPO		79.4	Gold	0.5631
GO-8	EPO		78.3	Gold	0.5562
GO-9	EPO		71.6	Silver	0.5075
GP-D	EPO		71.9	Silver	0.4974
GP-E	EPO		71	Silver	0.4870
GP-F	EPO		70.3	Silver	0.4788
GP-G	EPO	HSA	59.7	Bronze	0.4770
HL-E	EPO	HSA	69.3 - 71.8	Silver	0.5583
HL-G	EPO	HSA	68.8 - 71.6	Silver	0.5545
HL-F	EPO	HSA	68.8 - 71.6	Silver	0.5708
HL-H	EPO	HSA	69.3 - 71.8	Silver	0.5495
GP-H	EPO		71.6	Silver	0.5632
GP-I	EPO		71	Silver	0.5232
GP-J	EPO		70.1	Silver	0.5085
GP-K	EPO		68.1	Silver	0.4898
GK-W	EPO		68.4	Silver	0.4781

The HSA contributions range from $0 - $400

NW Indiana

Medical Plan Code	Product Type	HSA/HRA	Actuarial Value	Metallic Designation	Benefit Relativity
GK-4	POS		0.914	Platinum	0.7321
GK-5	POS		0.814	Gold	0.6474
GK-6	POS		0.813	Gold	0.6523
GK-7	POS		0.808	Gold	0.6295
GK-8	POS		0.813	Gold	0.5884
GK-9	POS		0.815	Gold	0.6389
GK-X	POS		0.790	Gold	0.6104
GK-Y	POS	HSA	0.798 - 0.813	Gold	0.7167
GK-Z	POS		0.820	Gold	0.6721
GL-1	POS		0.791	Gold	0.6125
GL-2	POS		0.801	Gold	0.6472
GL-3	POS	HRA	0.782 - 0.819	Gold	0.5225
GL-4	POS		0.786	Gold	0.6129
GL-5	POS	HSA	0.719	Silver	0.6334
GL-6	POS		0.813	Gold	0.6572

The HSA/HRA contributions range from $0 - $750

NW Indiana

Medical Plan Code	Product Type	HSA/HRA	Actuarial Value	Metallic Designation	Benefit Relativity
GL-7	POS		0.781	Gold	0.5568
GL-8	POS		0.788	Gold	0.6080
GL-9	POS		0.786	Gold	0.5437
GL-J	POS	HSA	0.683 - 0.717	Silver	0.4679
GL-K	POS		0.717	Silver	0.4831
GL-L	POS		0.814	Gold	0.5892
GL-M	POS		0.813	Gold	0.5936
GL-N	POS		0.808	Gold	0.5728
GL-O	POS		0.815	Gold	0.5814
GL-P	POS		0.790	Gold	0.5554
GL-Q	POS	HSA	0.798 - 0.813	Gold	0.6522
GL-R	POS		0.820	Gold	0.6116
GL-S	POS		0.791	Gold	0.5574
GL-T	POS		0.801	Gold	0.5889
GL-U	POS	HRA	0.783 - 0.819	Gold	0.4755
GL-V	POS		0.786	Gold	0.5577
GL-W	POS	HSA	0.719	Silver	0.5764
GL-X	POS		0.788	Gold	0.5533
GL-Y	POS	HSA	0.683 - 0.717	Silver	0.4258
Code1	POS	HSA	0.602 - 0.618	Bronze	0.5170
Code2	POS	HSA	0.592 - 0.616	Bronze	0.4494
Code3	POS		0.814	Gold	0.6264
D1-5	POS		0.699	Silver	0.5456
D1-6	POS		0.694	Silver	0.5390
D2-2	POS		0.803	Gold	0.6109
D2-3	POS		0.713	Silver	0.5532
DY-1	POS		0.718	Silver	0.5447
Code4	POS	HSA	0.602 - 0.618	Bronze	0.4705
Code5	POS	HSA	0.592 - 0.616	Bronze	0.4090
Code6	POS		0.814	Gold	0.5700
Code7	POS		0.699	Silver	0.4965
Code8	POS		0.694	Silver	0.4905
Code9	POS		0.803	Gold	0.5559
Code10	POS		0.713	Silver	0.5034
Code11	POS		0.718	Silver	0.4957

The HSA/HRA contributions range from $0 - $750

iv. The rating formula for UnitedHealthcare small employer group business is shown below:

Rating Formula with Example

	Item / Formula	2014 Q1
Base Rate	BR	761.00
Geographic Factor	AF	0.5740
Adjusted Start Rate	ASR = BR x AF	436.81
Quarterly Trend Factor	TF	1.0110
Benefit Plan Factor	BF	0.6003
Manual Rate	MR = ASR x TF x BF	265.10
Age Factor	Age	1.0000
Final Health Premium Rate	FHPR = MR x Age	265.10

Example for 23 year old, geographic rating area 16, benefit plan HL-D.

v. A rating example for UnitedHealthcare small employer group business is shown below:

Rating Example

Group is enrolling with 40 employees:

57 adults
20 contracts with child(ren):
7 with 1 child
10 with 2 or more children
3 with 3 or more children
Total # of children in rating formula = (7)(1) + (10)(2) + (3)(3) = 36

Distribution of membership for calculating target premium:

Member Age Group	Census		POS Base Premium Rates ***		Target Premium	
	Male	Female	Male	Female	Male	Female
Child	36	0	$ 168.34	$ 168.34	$ 6,060.19	$ -
<21	2	0	$ 168.34	$ 168.34	$ 336.68	$ -
23	1	2	$ 265.10	$ 265.10	$ 265.10	$ 530.20
26	1	1	$ 271.46	$ 271.46	$ 271.46	$ 271.46
28	3	1	$ 288.16	$ 288.16	$ 864.49	$ 288.16
30	2	2	$ 300.89	$ 300.89	$ 601.78	$ 601.78
31	3	3	$ 307.25	$ 307.25	$ 921.75	$ 921.75
32	2	3	$ 313.61	$ 313.61	$ 627.23	$ 940.84
37	0	2	$ 328.19	$ 328.19	$ -	$ 656.39
38	3	5	$ 330.31	$ 330.31	$ 990.94	$ 1,651.57
39	1	3	$ 334.56	$ 334.56	$ 334.56	$ 1,003.67
42	2	3	$ 351.26	$ 351.26	$ 702.52	$ 1,053.77
45	3	2	$ 382.80	$ 382.80	$ 1,148.41	$ 765.61
48	3	1	$ 433.44	$ 433.44	$ 1,300.32	$ 433.44
55	1	1	$ 591.17	$ 591.17	$ 591.17	$ 591.17
60	0	1	$ 719.48	$ 719.48	$ -	$ 719.48
Subtotal	57 Adults				$ 15,016.59	$ 10,429.30
TOTAL TARGET PREMIUM						$ 25,445.89

*** Base Premium rates use geographic rating area 16, benefit plan HL-D.

b. Non-Benefit Expenses

Administrative Expenses	8.3%
Taxes and Fees	9.9%
Risk Margin/Profit	6.2%

c. Impact of Contractual Arrangements

Our provider discounts in 2012 ranged from 35.5% - 48.5%.

Section 7 Company Financial Position

UnitedHealthcare Insurance Company ended 2012 with surplus of $4.7 billion.

The ratio of Adjusted Capital to the Authorized control level risk based capital was 532%.

Section 8 Small Group Attestation

UnitedHealthcare's Actuarial Certification for 2012, certifying UnitedHealthcare's compliance with IC 27-8-15, is on file with the Indiana Department of Insurance. The Actuarial Certification was mailed to the IDOI on 2/28/2013.

Section 9 Actuarial Certification/Rate Attestation

I, Lillian Dittrick, Director, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries (Academy). I satisfy the 2012 continuing professional development requirements of the Academy and therefore am qualified to issue this 2013 statement of actuarial opinion. In addition, I have reviewed applicable Actuarial Standards of Practice (ASOPs) during the preparation of this rate filing. I have worked on group health insurance for over 15 years.

Other Actuarial Disclosures

- This rate filing document is uniquely identified with date/time stamp and filename shown in the document footer
- The intended user of this rate filing is the Indiana Department of Insurance (IDOI)
- There are no cautions with regards to risk or uncertainty in the items discussed in this rate filing
- This rate filing should not be used for any other purpose than which is stated in **Section 1 (Purpose)**. Within that context, there are no limitations or constraints on the use or applicability of the rating items discussed herein.
- There are no conflicts of interest with regards to my production of this rate filing

All information is current-to-date shown in the footer; no information or subsequent event with any material impact has arisen since the production of this document

Final Comments

This concludes UnitedHealthcare's rate filing. Should you need additional information, please contact me as shown below.

Respectfully submitted,



Lillian Dittrick, FSA, MAAA

UnitedHealthcare
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West Des Moines, IA 50266
(515) 727-2091
Lillian_dittrick@uhc.com

Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For UnitedHealthcare Insurance Company

State of Indiana Rate Review

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FEDERAL Rate Justification PART III – Actuarial Memorandum & Actuarial Certification

Purpose

The purpose of this actuarial memorandum is to provide information relevant to the Part I Health Uniform Rate Review Template (HURRT).

This document contains information that consists of confidential, proprietary trade secrets under state and federal law. Under federal law, this information is exempt from disclosure under Exemption 4 of the U.S. Freedom of Information Act, 5 U.S.C. §552, is a trade secret or confidential commercial or financial information as defined in 45 CFR §5.65, and protected from disclosure under 45 CFR §§5.1 – 5.69, and 45 CFR §154.215 (i)(2).

The attached document contains confidential, proprietary information and trade secrets. This information is strictly confidential and protected from disclosure by Ind. Code Ann. §§ 27-1-3.1-15 and 5-14-3-3.

General Information

Company Identifying Information

Company Legal Name: UnitedHealthcare Insurance Company

State: Indiana

HIOS Issuer ID: 72850

Market: Small business, 2-50

Effective Date: 1/1/14

Company Contact Information

Primary Contact Name: Lillian Dittrick

Primary Contact Telephone Number: 515-727-2091

Primary Contact Email Address: Lillian_Dittrick@uhc.com

Proposed Rate Increase(s)

UnitedHealthcare Insurance Company in Indiana issues group major medical products.

Reason for Rate Increase(s)

UnitedHealthcare is filing 2014 rates for new benefit plans that meet the coverage and rating requirements of the Patient Protection and Affordable Care Act, , as amended by the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA).

New benefit plans are being offered at each of the new metallic levels: platinum, gold, silver and bronze.

In addition, rating factors are being revised to comply with ACA provisions, which eliminates medical underwriting and all rating factors other than: age (limited to 3:1 band for adults), geography, tobacco use, and family composition. The impact of transitioning to these new rating factors in 2014 will vary significantly by group.

The primary drivers of the proposed rate increase(s) are the following:

- Changes in medical service costs
- Changes in benefits
- Administrative costs and anticipated profit

Changes in Medical Service Costs

There are many different health care cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which can mean a premium rate increase to cover costs. Some of the key health care cost trends that have affected this year's rate actions include:

- **Increasing Cost of Medical Services** – Annual increases in reimbursement rates to health care providers – such as hospitals, doctors and pharmaceutical companies.
- **Increased Utilization** – The number of office visits and other services continues to grow. In addition, total health care spending will vary by the intensity of care and/or use of different types of health services. Patients who are sicker generally have a higher intensity of health care utilization. The price of care can be affected by the use of expensive procedures such as surgery vs. simply monitoring or providing medications.
- **Higher Costs from Deductible Leveraging** – Health care costs continue to rise every year, while deductibles and copayments remain the same. As a result, a greater percentage of health care costs need to be covered by health insurance premiums each year.
- **Cost shifting from the public to the private sector** – Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals are no longer covering all of the cost of care. The cost difference is being shifted to private health plans. Additionally, Medicare and Medicaid rates to hospitals are expected to decline due to the impact of the Patient Protection and Affordable Care Act on Medicare and the effect of the recession on Medicaid. A rate increase paid by Medicaid to hospitals is often below the actual cost increase hospitals will experience.
- **Impact of New Technology** – Improvements to medical technology and clinical practice require use of more expensive services - leading to increased health care spending and utilization.

Changes in Benefits

Coverage Mandates – Benefits are being enhanced to the meet Essential Health Benefits (EHBs) and other ACA requirements such as the introduction of pediatric dental and vision benefits. Plans will no longer include internal dollar limits on EHBs, and all customer copays, including prescription drug copays, will count towards satisfying the overall plan out-of-pocket maximum.

Administrative Costs and Anticipated Profit

UnitedHealthcare works to directly control administrative expenses by adopting better processes and technology, and through the development of programs and innovations that make health care more affordable. We have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions.

Additionally, UnitedHealthcare indirectly controls medical cost payments by using appropriate payment structures with providers and facilities. UnitedHealthcare's goal is to control costs, maximize efficiency, and work closely with physicians and providers to obtain the best value and coverage.

In addition, increases in State and/or Federal government imposed taxation and fees are another significant factor that impacts health care spending. These fees include new ACA taxes and fees which will increase health insurance costs and need to be reflected in premium. A review of the current UnitedHealthcare premium rate indicates that the rate is not sufficient to cover the administrative costs. The requested rate increase is anticipated to be sufficient to cover the projected additional administrative costs in 2014.

Experience Period Premium and Claims

Experience Period, Paid Through Date

The experience period is 1/1/12 to 12/31/12, paid through 2/28/13. The experience includes both grandfathered and non-grandfathered policies; at this time, the experience is unable to be separated based on grandfathered status.

Experience Period – Premiums

Total earned premium in 2012 was $167,360,000. Anticipated 2012 MLR rebates are $1,500,000. Therefore, total premiums (net of MLR Rebate) are $165,860,000.

Experience Period – Allowed and Incurred Claims

Incurred claims were developed by first starting with actual claims paid through 2/28/13 sorted by incurred date. Estimates of incurred but not paid were added to these paid claims. The following is a description of the reserve methodology:

The UnitedHealthcare Reserving process utilizes the Reserve Production System (RPS) to record reserves into the PeopleSoft general ledger. Fee for service and paid claim data is loaded into RPS and becomes the basis for the monthly reserve calculations at the various business unit, location, and line of business levels. The assignment of the paid claims into RPS packages is based on the mapping rules maintained by the Corporate Actuarial department. RPS calculates a preliminary best estimate Incurred But Not Reported (IBNR) for each reserving model (package) primarily using standard completion factors based on historical claim experience. The Claims Reserving Team adjusts the preliminary IBNR based on specific knowledge of the entity (i.e. catastrophic claims, pended claims, etc.) to calculate the final IBNR. In months where adjudicated claims experience is not complete enough for an estimate using completion factors, a seasonally adjusted PMPM is used to estimate incurred claims.

A description of the Sarbanes Oxley controls, audited by Deloitte & Touche, in place regarding the reserving process includes:

- Market Paid claim Tie-outs: To verify completeness and accuracy of financial data in RPS, paid claim data is tied out between source system (RPS) and PeopleSoft general ledger.
- Market Expense Tie-outs: RPS reserve changes on the income statement are tied to the PeopleSoft general ledger to ensure that information is accurate subsequent to computing the reserve.

Allowed claims by benefit category were obtained from UnitedHealthcare claim paying system reports.

Benefit Categories

Claims were assigned to benefit categories by our claim department using standard industry definitions of services.

- **Inpatient Hospital:** Includes non-capitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- **Outpatient Hospital:** Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, ambulance, home health care, DME, other services provided in an outpatient facility setting and billed by the facility.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.
- **Other Medical:** Includes non-capitated, fee-for-service costs for physician procedures, inpatient stay, or and outpatient procedure related to Mental Health / Chemical Dependency (MHCD).
- **Capitation:** Includes all MHCD services provided under capitated arrangement.
- **Prescription Drug:** Includes drugs dispensed by a pharmacy, not dispensed by facility (i.e. via inpatient, outpatient), and not physician administered drugs. This amount is net of rebates received from drug manufacturers.

Projection Factors

Insured Population Morbidity Changes

Morbidity is expected to change in 2014 due to the following:

- The expected health status of new, non-medically underwritten groups
- Anti-selection from disruption in the historical renewal pattern due to ACR (Adjusted Community Rating)
- The removal of grandfathered experience from the single risk pool

These adjustments are shown in the "Pop'l risk Morbidity" column on Worksheet 1, Section II.

Projection Factors

Insured Population Morbidity Changes

Morbidity is expected to increase 3.2% in 2014. This is due to the following:

- The expected health status of new, non-medically underwritten groups
- The expected health status of groups opting to renew early in 2014 due to the favorable impact of adjusted community rating
- The removal of grandfathered experience from the single risk pool

Benefit Changes

Claims are expected to increase due to additional benefits required by the essential health benefit package. The estimate of the cost of added essential health benefits was developed using UnitedHealthcare national experience and is included in the "Other" adjustments column on Worksheet 1, Section II. The primary drivers of this increase are the following:

- The addition of pediatric dental coverage
- The addition of pediatric vision coverage
- Increasing DME coverage to unlimited coverage
- The addition of private duty nursing coverage

Demographics Changes

Demographic changes, including aging of the population and the premium cap on the number of members in a given family, have been included in the "Other" adjustments column on Worksheet 1, Section II. The HHS proposed age factors are used in rating.

Other Adjustments

No other adjustments were made.

Trend Factors (Cost, Utilization)

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, benefit leveraging, and business mix identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected net of business mix (employer mix, benefit mix, demographic mix, etc.). Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence mix of procedures.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Business mix changes that influence medical cost trends are also reviewed and projected, with appropriate input from sales and underwriting staff. These factors include changing mix of employer groups, mix of benefits, and demographic changes. For the purposes of developing premium pricing trend projections, the component of trend attributable to business mix is excluded.

Credibility Manual Rate Development

Experience Data Used

UnitedHealthcare Insurance Company's experience includes 406,596 member months. We assign full credibility at 30,000 member years or the equivalent 360,000 member months. Therefore, UnitedHealthcare Insurance Company's experience is considered fully-credible. No manual rate adjustment is used.

Experience Credibility

Not applicable.

Paid To Allowed Ratio

The paid to allowed average factor for the projection period is based on the actual paid to allowed in the experience period, adjusted for expected leveraging and migration to new plans.

Risk Adjustment and Reinsurance

Projected Risk Adjustments (PMPMs)

No risk adjustment is being projected.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

Since the state of Kentucky chose not to combine its individual and small group markets, reinsurance recoveries are not applicable to this rate filing. However, reinsurance premiums of $5.25 PMPM are assumed to be charged. The URRT template does not allow this assumption to be entered in the designated cell (for Small Group). Instead, the Taxes & Fees assumption includes contributions to the Federal transitional reinsurance program.

Non-Benefit Expenses and Risk Margin

Administrative Expenses

The administrative expense assumption is a long-term estimate of administrative expenses, including commissions, management fees, and other SG&A. This load does not vary by product or plan.

Profit & Risk Margin

The profit and risk load includes a 1% risk contingency assumption.

Taxes and Fees

The taxes and fees assumption includes insurer fees, premium taxes, federal income taxes, the PCORI fee, and contributions to the Federal transitional reinsurance program. Contributions to the Federal transitional reinsurance program are included in this assumption because the designated cell does not allow the reinsurance premium to be entered there.

% of Premium Taxes & Fees	UHIC of IN
Reinsurance Fees	1.02%
Premium Tax and Fees	4.40%
FIT	4.50%
	9.90%

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is 79%. There is a 1% risk contingency assumption, and when included, the projected loss ratio is 80%. If the actual loss ratio is below the 80% MLR requirement for small business, rebates will be paid as the law requires.

Index Rate

The index rate for the experience period is equal to the allowed claims PMPM. No adjustments have been made to account for essential health benefits that were not covered during the experience period. Benefits that are in excess of EHBs are estimated to be a de-minimis amount less than 2%, and therefore, the allowed claims were not adjusted to exclude these benefits. No adjustments were made for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees.

The index rate for the projection period of $500.40, is the weighted average of the projected allowed claims applicable for each effective date. The projection period (1/1/14 – 12/31/14) projected allowed experience claims PMPM is trended to the midpoint of each quarter in 2014. The trend assumption includes the same cost and utilization trend factors used in Section II of Worksheet 1. The weighted average was based on the projected member months with effective dates for policy periods beginning in each quarter of 2014. The calculation is shown below.

	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Average
2014 Projected Allowed Claims	$ 484.29	$ 484.29	$ 484.29	$ 484.29	$ 484.29
Trend to Midpoint of each Quarter	1.010	1.029	1.049	1.069	1.033
Index Rate	$ 488.94	$ 498.37	$ 507.97	$ 517.77	$ 500.40
Member Months	160,560	77,124	95,628	73,284	406,596

Projected benefits that are in excess of essential health benefits are estimated to be a de-minimis amount less than 2%, and therefore the allowed claims were not adjusted to exclude these benefits. No adjustments for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees were made to the index rate calculation above.

Each projected quarterly index rate is adjusted for the following factors in order to arrive at a premium rate:

- Expected aggregated payments and charges under the risk adjustment and reinsurance programs
- Actuarial value and cost-sharing structure of the plan
- The plan's provider network, delivery system characteristics, and utilization management practices
- Plan benefits in addition to the essential health benefits
- Distribution costs and other administrative costs
- Whether the plan or coverage covers an individual or family
- Rating area
- Age (within a ratio of 3:1 for adults)

AV Metal Values

All AV Metal Values were based on the AV Calculator. Some adjustments were made to plan designs in order to appropriately model the designs in the AV Calculator. When possible, data from the AV Calculator was used to make the adjustments. If the necessary data from the AV Calculator was not available, adjustments were developed based on UnitedHealthcare's historical experience and proprietary pricing model. These adjustments include the following:

- **Specialty Rx copays:** 24 of the filed plan designs include multiple copay tiers for specialty Rx. A weighted average of the specialty Rx copays was used in the AV Calculator, based on UnitedHealthcare's historical experience and proprietary pricing model.
- **Copays after the deductible converted to effective coinsurance:** A number of the HSA plan designs feature copays which apply after the deductible. These copays were converted to an equivalent effective coinsurance rate based on the continuance tables included in the AV Calculator.
- **OP Surgery Facility Copays:** Three plan designs include a per-occurrence copay which applies to outpatient surgery facility claims before applying the deductible and coinsurance benefits. This copay was converted to an equivalent effective coinsurance rate based on UnitedHealthcare's historical experience and proprietary pricing model. The tiered network functionality in the AV Calculator was used to run the plans through the model in two ways: once with the effective outpatient surgery facility coinsurance rate and once with the coinsurance rate for other OP service types. The tiered network weights were based on UnitedHealthcare's historical experience and proprietary pricing model.
- **IP Facility Copay:** Three plan designs include a per-occurrence copay which applies to inpatient facility claims before applying the deductible and coinsurance benefits. This copay was converted to an equivalent effective coinsurance rate based on the continuance tables included in the AV Calculator. The tiered network functionality in the AV Calculator was used to run the plans through the model in two ways: once with the effective facility coinsurance rate and once with the professional coinsurance rate. The tiered network weights were based on UnitedHealthcare's historical experience and proprietary pricing model.
- **ER Cost Sharing Converted to Effective Coinsurance:** A number of the plan designs feature an emergency room copay followed by coinsurance. The copay and coinsurance together were converted to an equivalent effective coinsurance rate based on the continuance tables included in the AV Calculator.
- **Premium Designation:** Five plan designs feature different coinsurance levels for inpatient and outpatient as well as a copay/coinsurance tiering for PCP and Specialist ("Premium Designated" providers). The plans were run through the model three times. The first run used the premium designated (tier one) benefits. The second run used the non-premium designated (tier two) benefits except for PCP. The third run used the non-premium designated benefits. Additionally, not all specialties are included in the premium designation program; for these benefits, weighted averages of the cost-sharing requirements were used. The tiered network weights and average cost-sharing weights were based on UnitedHealthcare's historical experience and proprietary pricing model.

  The following chart outlines which adjustments were made to each plan included in this filing:

Plan Name	Plan ID	Metallic Level	AV Score	Specialty Rx Copays	Copays After the Deductible Converted to Effective Coinsurance	99.9% Coinsurance	Varying Coinsurance Rates on IP Facility and IP Professional	Combined Copay Limit on PCP/Specialist	OP Surgery Facility Copay	IP Facility Copay	ER Cost Sharing Converted to Effective Coinsurance	Premium Designation	HSA Contribution Amount
HL-D	72850IN0030001	Gold	80.1	x	N	N	N	N	N	N	Y	N	N/A
HK-8	72850IN0030002	Gold	78.3	x	N	N	N	N	N	N	Y	N	N/A
HK-9	72850IN0030003	Silver	71.7	x	N	N	N	N	N	N	Y	N	N/A
GE-U	72850IN0030004	Silver	71.9	x	N	N	N	N	N	N	Y	N	N/A
GE-V	72850IN0030005	Silver	70.3	x	N	N	N	N	N	N	Y	N	N/A
HK-7	72850IN0030006	Silver	71.3	x	N	N	Y	N	N	N	Y	N	N/A
HG-8	72850IN0030007	Silver	71.7	x	N	N	Y	N	N	N	Y	N	N/A
HK-6	72850IN0030008	Silver	70.5	x	N	N	Y	N	N	N	Y	N	N/A
FN-9	72850IN0030009	Gold	79.4	x	N	N	N	N	N	N	Y	N	N/A
GO-8	72850IN0030010	Gold	78.3	x	N	N	N	N	N	N	Y	N	N/A
GO-9	72850IN0030011	Silver	71.6	x	N	N	N	N	N	N	Y	N	N/A
GP-D	72850IN0030012	Silver	71.9	x	N	N	N	N	N	N	Y	N	N/A
GP-E	72850IN0030013	Silver	71.0	x	N	N	N	N	N	N	Y	N	N/A
GP-F	72850IN0030014	Silver	70.3	x	N	N	N	N	N	N	Y	N	N/A
**GP-G	72850IN0030015	Bronze	60.1	x	Y	N	N	N	N	N	Y	N	$0
*HL-E	72850IN0030016	Silver	70.0	x	Y	Y	N	N	N	N	Y	N	$300
*HL-G	72850IN0030017	Silver	70.2	x	N	N	N	N	N	N	N	N	$300
*HL-F	72850IN0030018	Silver	69.9	x	Y	Y	N	N	N	N	Y	N	$100
*HL-H	72850IN0030019	Silver	70.0	x	Y	Y	N	N	N	N	Y	N	$300
GP-H	72850IN0030020	Silver	71.6	x	N	N	N	N	Y	Y	N	Y	N/A
GP-I	72850IN0030021	Silver	71.0	x	N	N	N	N	N	N	Y	Y	N/A
GP-J	72850IN0030022	Silver	70.1	x	N	N	N	N	N	N	Y	Y	N/A
GP-K	72850IN0030023	Silver	68.1	x	N	N	N	N	N	N	Y	Y	N/A
GK-W	72850IN0030024	Silver	68.4	x	N	N	N	N	N	N	Y	Y	N/A
GK-4	72850IN0010001	Platinum	91.4	N	N	N	N	N	N	N	N	N	N/A
GK-5	72850IN0010002	Gold	81.4	N	N	N	N	N	N	N	N	N	N/A
GK-6	72850IN0010003	Gold	81.3	N	N	N	N	N	N	N	N	N	N/A
GK-7	72850IN0010004	Gold	80.8	N	N	N	N	N	N	N	N	N	N/A
GK-8	72850IN0010005	Gold	81.3	N	N	N	N	N	N	N	N	N	N/A
GK-9	72850IN0010006	Gold	81.5	N	N	N	N	N	N	N	N	N	N/A
GK-X	72850IN0010007	Gold	79.0	N	N	N	N	N	N	N	N	N	N/A
GK-Y	72850IN0010008	Gold	79.8	N	N	N	N	N	N	N	N	N	$0
GK-Z	72850IN0010009	Gold	82.0	N	N	N	N	N	N	N	N	N	N/A
GL-1	72850IN0010010	Gold	79.1	N	N	N	N	N	N	N	N	N	N/A
GL-2	72850IN0010011	Gold	80.1	N	N	N	N	N	N	N	N	N	N/A
GL-3	72850IN0010012	Gold	78.2	N	N	N	N	N	N	N	N	N	$750
GL-4	72850IN0010013	Gold	78.6	N	N	N	N	N	N	N	N	N	N/A
GL-5	72850IN0010014	Silver	71.9	N	N	N	N	N	N	N	N	N	$0
GL-6	72850IN0010015	Gold	81.3	N	N	N	N	N	N	N	N	N	N/A
GL-7	72850IN0010016	Gold	78.1	N	N	N	N	N	N	N	N	N	N/A
GL-8	72850IN0010017	Gold	78.8	N	N	N	N	N	N	N	N	N	N/A
GL-9	72850IN0010018	Gold	78.6	N	N	N	N	N	N	N	N	N	N/A
GL-J	72850IN0010019	Silver	68.3	N	N	N	N	N	N	N	N	N	$500
GL-K	72850IN0010020	Silver	71.7	N	N	N	N	N	N	N	N	N	N/A
GL-L	72850IN0010021	Gold	81.4	N	N	N	N	N	N	N	N	N	N/A
GL-M	72850IN0010022	Gold	81.3	N	N	N	N	N	N	N	N	N	N/A
GL-N	72850IN0010023	Gold	80.8	N	N	N	N	N	N	N	N	N	N/A
GL-O	72850IN0010024	Gold	81.5	N	N	N	N	N	N	N	N	N	N/A
GL-P	72850IN0010025	Gold	79.0	N	N	N	N	N	N	N	N	N	N/A
GL-Q	72850IN0010026	Gold	79.8	N	N	N	N	N	N	N	N	N	$0
GL-R	72850IN0010027	Gold	82.0	N	N	Y	N	N	N	N	N	N	N/A
GL-S	72850IN0010028	Gold	79.1	N	N	N	N	N	N	N	N	N	N/A
GL-T	72850IN0010029	Gold	80.1	N	N	Y	N	N	N	N	N	N	N/A
GL-U	72850IN0010030	Gold	78.3	N	N	N	N	N	N	N	N	N	$750
GL-V	72850IN0010031	Gold	78.6	N	N	N	N	N	N	N	N	N	N/A
GL-W	72850IN0010032	Silver	71.9	N	N	N	N	N	N	N	N	N	$0
GL-X	72850IN0010033	Gold	78.8	N	N	N	N	N	N	N	N	N	N/A
GL-Y	72850IN0010034	Silver	68.3	N	N	N	N	N	N	N	N	N	$500
Code1	72850IN0010035	Bronze	60.2	N	N	N	N	N	N	N	N	N	N/A
Code2	72850IN0010036	Bronze	59.2	N	N	N	N	N	N	N	N	N	N/A
Code3	72850IN0010037	Gold	81.4	N	N	N	N	N	N	N	N	N	N/A
D1-5	72850IN0010038	Silver	69.9	N	N	N	N	N	N	N	Y	N	N/A
D1-6	72850IN0010039	Silver	69.4	N	N	N	N	N	N	N	Y	N	N/A
D2-2	72850IN0010040	Gold	80.3	N	N	N	N	N	N	N	N	N	N/A
D2-3	72850IN0010041	Silver	71.3	N	N	N	N	N	Y	Y	N	N	N/A
DY-1	72850IN0010042	Silver	71.8	N	N	N	N	N	Y	Y	N	N	N/A
Code4	72850IN0010043	Bronze	60.2	N	N	N	N	N	N	N	N	N	N/A
Code5	72850IN0010044	Bronze	59.2	N	N	N	N	N	N	N	N	N	N/A
Code6	72850IN0010045	Gold	81.4	N	N	N	N	N	N	N	N	N	N/A
Code7	72850IN0010046	Silver	69.9	N	N	N	N	N	N	N	Y	N	N/A
Code8	72850IN0010047	Silver	69.4	N	N	N	N	N	N	N	Y	N	N/A
Code9	72850IN0010048	Gold	80.3	N	N	N	N	N	N	N	N	N	N/A
Code10	72850IN0010049	Silver	71.3	N	N	N	N	N	Y	Y	N	N	N/A
Code11	72850IN0010050	Silver	71.8	N	N	N	N	N	Y	Y	N	N	N/A

*These plans are HSAs with assumed employer contributions of $300 (plans HL-E, HL-G, and HL-H) and $100 (plan HL-F). For each of these plans, there is a contribution range ($200-$400 for HL-E, HL-G, and HL-H and $0-$200 for HL-F) which has a de-minimis impact to the AV. Within these ranges, the plans qualify at the silver metallic level.

**This plan is an HSA with an assumed employer contribution of $0 (plan GP-G). For this plan, there is a contribution range ($0-$100) which has a de-minimis impact to the AV. Within this range, the plan qualifies at the bronze metallic level.

AV Pricing Values

The fixed reference plan used for the AV Pricing Values is a plan that covers 100% of allowed claims. This is not a plan design that will be offered, but making this the assumed reference plan keeps the AV Pricing Values consistent with the AV Metal Values. 100% of the AV Pricing Value is attributable to the cost-sharing design of the plans.

Membership Projections

All of the current non-grandfathered plans will be terminated upon renewal in 2014, and groups will be offered new plans compliant with the new 2014 requirements. February 2013 membership on current plans was mapped to similar plans which will be offered in 2014. Groups were assumed to migrate to the new plans upon renewal. No persistency or new business sales assumptions were included in the projected membership.

In Worksheet 1, the projected membership is based on the projection period of calendar year 2014. The projected member months include membership on new plans during the year 2014, as well as member months on terminated plans prior to their 2014 renewal effective date. In Worksheet 2, the projected member months is based solely on the 2014 renewal effective dates for each plan, regardless of whether the policy period extends beyond the end of 2014.

Terminated Products

No products are being terminated. Plan designs which are not compliant in 2014 will not be renewed. All terminated plans have the product ID "72850IN000." The rate change over prior filing and cumulative rate change are assumed to be 0% for terminated plans, per guidance during the 4/18/13 presentation by the American Academy of Actuaries and CCIIO.

Plan Type

All plans fall under the EPO or POS plan type.

Warning Alerts

There is one warning alerts due to differences between the plan level projections in Worksheet 2 and the total projected amounts found on Worksheet 1:

- **Total Premium:** The total premium in Worksheet 2 is higher than the total premium in Worksheet 1 because the average rate PMPM in Worksheet 2 is higher than the average rate PMPM in Worksheet 1.

Reliance

I have relied on UnitedHealthcare's Finance Department to provide the Non-Benefit Expenses and Risk Margin information, including administrative expenses, profit and risk margin, taxes and fees, and the projected loss ratio under the Federally prescribed MLR methodology.

Actuarial Certification

I, Lillian L. Dittrick am an actuary of UnitedHealthcare and a member of the American Academy of Actuaries.

I certify that the projected index rate is:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice,
- Reasonable in relation to the benefits provided and the population anticipated to be covered, and
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents EHBs included in Worksheet 2, Sections III and IV was calculated in accordance with actuarial standards of practice.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. For plans designs that did not fit into the AV Calculator, included in this Part III Actuarial Memorandum is a description of the methodology and numerical values used to develop the AV metal values, and a certification as required by 45 CFR Part 156, §156.135.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges, and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,



Lillian Dittrick, FSA, MAAA
Actuary, UnitedHealthcare
1089 Jordan Creek Parkway
West Des Moines, IA 50266
515-727-2091

Formulary Inadequate Category/ Class Count Supporting Documentation And Justification

Please fill in the following information.

HIOS Issuer ID **IN**

Drug List ID(s)	Category	Class	Justification*
1,2,3	GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	TROSPIUM CHLORIDE EXTENDED RELEASE CAPSULES ARE EXCLUDED BUT IMMEDIATE RELEASE TABLETS ARE COVERED ON THE PDL.
1,2,3	VARIOUS	VARIOUS	SELECT MEDICAL BENEFIT DRUGS WERE INCLUDED IF NEEDED TO ACHIEVE THE NUMBER OF COVERED DRUGS IN EACH CLASS. RXCUIs FOR INCLUDED MEDICAL BENEFIT DRUGS ARE PROVIDED ON THE ATTACHMENT.

***** Choose the appropriate letter in the Justification column or use free text to describe an "other" justification.

A = Drugs in this category and class have been discontinued by the manufacturer.

B = Drugs in this category or class have been deemed unsafe by the FDA or removed from market by the manufacturer due to safety concerns.

C = Drugs in this category and class have a DESI classification.

D = Drugs in this category or class have become available as generics during or after December 2012.

July 17, 2014

Subject: **All Savers Insurance Company**
Filing of Individual Health Rates
SERFF Tracking Number: UHLC-129514067
State Tracking Number: IEXPOL.I.15.IN

Dear Mr. Knable:

Thank you for your letter dated July 3, 2014. I have addressed your concerns below.

1. *With my question 15, please review page 5 in the Part 1, Unified Rate Review Template instructions about calibrating the age curve and provide a demonstration of this line.*

   Page 5 in the URRT Part 1 instructions notes, *"The calibration with respect to the age curve is allowed and identifies the value on the age curve associated with the weighted average age on the standard age curve."* The age calibration is illustrated below. The membership distribution is based upon on-exchange individual demographic data as of Feb 2014 provided by Wakely Consulting Group, as well as ACA off-exchange membership through the first quarter of 2014 of an affiliated carrier. We assumed a uniform distribution over each age band. The weighted average factor yielded below corresponds to an average age of 45.

   It is worth noting that the age calibration does not impact rates as the average age is reflected in both the Credibility Manual and the Age Calibration, and the value is therefore offset in the base rate calculation.

Age	Membership	Avg Age Factor
< 18	21.0%	0.635
18-25	9.0%	0.864
26-34	16.0%	1.130
35-44	16.0%	1.286
45-54	18.0%	1.763
55-64	20.0%	2.650
Total	100.0%	1.4448

2. *With my question 17, you are assuming that tobacco users comprise 5.8% of the policies. This may have been appropriate with currently issued business from an affiliated carrier. Can you rethink if this is appropriate considering that Indiana has a much higher population percentage of smokers?*

   We understand that Indiana's percent population of smokers (26% according to the Centers for Disease Control) is much higher than the 18% national average. However, Indiana also has fairly strong anti-tobacco policies in the state. Also, the 5.8% assumption is not a direct reflection of the percentage of the population that uses tobacco, but rather the percentage of insured members that will indicate that they use tobacco on the application. Therefore, we feel the assumption is reasonable.

3. *With question 18, please ask the affiliated small group carrier to provide a response. Additionally, please be aware that per section 4.1 of ASOP 8, you should disclose any material information supplied by other and the extent of your reliance on such information. If you have relied on data from other actuary's, we will need a certification from each actuary regarding their portion of the filing.*

   In response to your previous question 18, after further review of the Area Factor for Rating Area 1, it has been determined that a revision to the factor is appropriate. We are therefore updating the factor for this area to 0.778. Please see the attached updated rate book "*IN IEX 2015 Ratebook2.xlsx*" in the Supporting Documentation tab.

   In accordance with ASOP 8, section 4.1, reliance on the small group UnitedHealthcare actuaries for the small group rates, including geographic area factors, was disclosed in the Federal Actuarial Memorandum (Part III). The extent of the reliance falls under ASOP 41, section 4.3 (d)2, in that I was not able to judge the reasonableness of the assumptions without performing a substantial amount of additional work beyond the scope of the assignment.

   The affiliated carrier small group rates that were the basis of the reliance were filed and approved 2014 rates. They can be found under SERFF tracking number: UHLC-129094048. The Actuarial Memorandum and Federal Part III Actuarial Memorandum from that filing, which include the requested Actuarial Certifications, are also being provided in the Supporting Documentation tab.

4. *With regard to your formulary, it appears you are deficient in class category 114, Genitourinary Agents, in that trospium is not included.*

   A document was added to the Supporting Documentation tab named "IN Justification Form" that explains why parts of trospium are not included. This document was also included in the Binder Submission (UHLC-IN15-125013465).

If you have any further questions about this filing, please feel free to call me at (920) 661-1071 or e-mail me at jshallow@unitedhealthone.com.

Sincerely,



James M Shallow, ASA, MAAA
Associate Director, Actuarial Services

All Savers Insurance Company

Choice Individual Medical Policy

7440 Woodland Drive

Indianapolis, Indiana 46278-1719

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if: (A) we do not receive premiums when due, as described in the Policy; (B) a Covered Person has committed an act of fraud or made an intentional misrepresentation in connection with the Policy; (C) we discontinue offering and refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live; or (D) we discontinue offering and refuse to renew all individal policies/certificates in the individual market in the state where you reside. Please refer to Events Ending Your Coverage for further information.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

30-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 30 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, if any, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

- The study or investigation is conducted 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 clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits will also be provided for re-education or refresher training.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipmen*t. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug* subsection.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

5. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

11. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorder that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.

- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

13. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

14. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

15. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

16. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

17. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on

how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

18. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

19. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

20. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

21. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

23. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

24. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

25. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), chemotherapy (whether administered orally, intravenously, or by injection) or other intravenous infusion therapy and radiation oncology.

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

26. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

27. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

28. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

29. Autism Spectrum Disorder Medical Services

Benefits are provided on the same basis as any other Sickness for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by a treating Physician for the treatment of Autism Spectrum Disorder. Any exclusion within the Policy that is inconsistent with the treatment plan will not apply.

Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

30. Cancer Chemotherapy

Covered Health Services include chemotherapy for the treatment of cancer, whether administered orally, intravenously or by injection.

31. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by dentures or bridges.

32. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

33. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

34. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

35. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

36. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

37. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health

management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly associated with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA)*

Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).

- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.

- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
    - Extraction, restoration and replacement of teeth.
    - Medical or surgical treatments of dental conditions.
    - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
    - Blood pressure cuff/monitor.
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

- The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
- The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.
18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.
19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
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 may be made up to six times during a calendar

year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

~~I. Neurodevelopmental Disorders - Autism Spectrum Disorder~~

~~In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.~~

~~1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.~~

~~2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.~~

~~3. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.~~

~~4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.~~

~~5. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.~~

~~6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.~~

~~7. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*~~

~~8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:~~

~~- Medically Necessary.~~

- ~~Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.~~
- ~~Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.~~

~~J~~I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

~~K~~J. 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 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~~K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

~~M~~L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
15. In vitro fertilization regardless of the reason for treatment.

~~N~~M. 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 residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

~~O~~N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

4. The reversal of voluntary sterilization.

5. Fetal reduction surgery.

6. Abortion, except for Therapeutic Abortion.

~~P~~O. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

~~Q~~P. 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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.

3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.

5. Gambling disorders.

6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

~~R~~Q. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

~~S~~R. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

~~T~~S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

~~U~~T. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.

2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.

3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

4. Eye exercise or vision therapy.

5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.

2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.

3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

~~V~~U. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - ♦ Medically Necessary.
    - ♦ Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - ♦ Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:
    - ▪ Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - ▪ Related to judicial or administrative proceedings or orders.
    - ▪ Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
    - ▪ Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion

does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Subject to a determination of the Indiana Health Insurance Exchange, a newborn child of the Policyholder or the Policyholder's spouse will be covered from the time of birth until the 31st day after birth. Coverage will terminate on the 31st day following birth, unless we have received notice of the child's birth and any additional premium required. Coverage of the newborn child shall include coverage of Sickness and Injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including intpatient and outpatient expenses arising from medical and dental treatment involved in the management of cleft lip and cleft palate.

Subject to a determination of the Indiana Health Insurance Exchange, a child placed for adoption with the Policyholder or the Policyholder's spouse will be covered from the date of Placement until the 31st day following Placement unless the Placement is disrupted prior to legal adoption and the child is removed from the insured's custody. Coverage will terminate on the 31st day following Placement, unless we have received notice of the intent to adopt the child and any additional premium required.

"Placement" when used in reference to an adoption, means the earlier of:

- The date of placement for the purpose of adoption.
- The date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you~~,~~ or a third party identified above.~~, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.~~

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Time Limit on Certain Defenses

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent mistatements, made in the application for coverage shall be used to void the Policy or deny a claim for loss incurred after the expiration of this two year period.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Filing a Grievance

A grievance is any dissatisfaction expressed by, or on your behalf, regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Investigational Service
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between you and us; or
- Our decision to rescind the Policy

And for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

A grievance may be submitted orally or in writing. You or a person acting on your behalf may file a grievance.

The written request may be sent directly to us at the following address:

All Savers Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]

We will conduct a full and fair review of your grievance. The review of your grievance will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

We will acknowledge our receipt of your grievance, either orally or in writing, within 5 business days after receipt of the grievance. Grievances regarding appropriateness, medical necessity, or Experimental or Investigational Services will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination. All other grievances will be reviewed by at least one individual who:

- Was not involved in the making the original determination;
- Is not the subordinate of the original reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the grievance.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the grievance.

Grievance Determinations

For procedures associated with urgent requests for benefits, see Urgent Grievances that Require Immediate Action below.

You will be provided written or electronic notification of the decision as follows:

- For services not yet received:

- The grievance review will be resolved as quickly as possible but not more than 15 calendar days from receipt of a grievance of a denied request for benefits. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 15 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

- For all other grievances:
  - The grievance review will be resolved as quickly as possible, but not more than 20 business days after receiving all information reasonably necessary to complete the review. If we are unable to make a decision regarding the grievance within the 20 day period due to circumstances beyond our control, we will notify in writing before the 20th business day. We will then issue a written decision within a total of 30 calendar days after receipt of the grievance, regardless of whether all information has been received. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

Urgent Grievances that Require Immediate Action

Your grievance may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The grievance does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your grievance.

The grievance process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Internal Appeals Review

If you are not satisfied with the grievance decision, you have the right to appeal, orally or in writing, within 60 calendar days from your receipt of our grievance decision.

We will acknowledge our receipt of your appeal, either orally or in writing, within 5 business days after receipt of the appeal. If your appeal involves appropriateness, medical necessity, or experimental or investigational treatment, we will appoint a panel of one or more qualified individuals to resolve the appeal. The panel will include one or more individuals who:

- Have knowledge of the medical condition, procedure, or treatment at issue;
- Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
- Were not involved in the initial determination or the grievance review; and
- Do not have a direct business relationship with you or your provider who previously recommended the health care procedure, treatment, or service giving rise to the appeal.

You have the right to appear in person before the panel to present your case. If you are unable to appear in person, you have the right to otherwise appropriately communicate with the panel.

All other appeals of grievances that are based in whole or in part on a medical judgment will be reviewed in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination or the grievance review.
If the appeal concerns a rescission, a panel of individuals who were not involved in the original determination and who are not subordinates of the original reviewer will review the appeal.

All other appeals will be reviewed by an impartial person who:

- Was not involved in the making the original determination or the grievance review;
- Is not the subordinate of the original reviewer or the grievance reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the appeal.

The review of your appeal will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the appeal.

Appeal Determinations

For procedures associated with urgent requests for benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision as follows:

- For services not yet received:
  - An appeal of a grievance decision will be resolved as quickly as possible but not more than 15 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of5 business days after the investigation is complete or 15 calendar days after the appeal is received.
- For all other grievances :
  - An appeal of a grievance decision will be resolved as quickly as possible, but not more than 30 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the appeal is received.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal review process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

Please note that our decision is based only on whether or not benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your appeal.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review

If, after exhausting our internal review process, you are not satisfied with the decision made by us, you may be entitled to request an external review. You may request an external review of a grievance or appeal regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Iinvestigational Service; or
- Our decision to rescind your Policy.

An external review may be requested within 120 days after receipt of our appeal decision. You may request a standard external review by sending a written request to the address set out in the decision letter. If the grievance or appeal is related to an illness, disease, condition, injury, or a disability for which the time frame for a standard review would seriously jeopardize your life or health or you ability to reach and maintain maximum function, an expedited review will be allowed. An expedited external review may be requested by calling the toll-free number on your ID card or by sending a written request to the address set out in the decision letter.

We are responsible for selecting an IRO from the list of IROs that are certified by the State of Indiana Department of Insurance. A different IRO must be selected for each external review and we will not repeat a selection until all IROs have been used.

Reconsideration during the External Review Process

If, at any time during the external review process, you submit information to us that was not previously submitted for review, we have the right to reconsider our decision. At such time additional information is received and we wish to reconsider our decision, we shall notify the IRO and the external review will cease.

We will have 15 days to review the additional information and reconsider our decision. In the case of an expedited review, we will make a decision within 72 hours. We will notify you of our decision.

If we determine to uphold our original decision, you may request that the IRO resume the external review.

If we choose not to reconsider the additional information submitted, we will forward the information to the IRO within 2 business days of receipt of the information.

External Review Decision

In the case of a non-expedited review, the IRO's decision is to be made within 15 business days after the request is filed. The IRO is to notify us and you of the decision within 72 hours after making the decision.

An expedited review must be completed within 72 hours after all information is submitted to the IRO. The IRO is to notify us and you of the decision within 24 hours after making the decision.

~~Section 6: Questions, Complaints and Appeals~~

~~To resolve a question, complaint/grievance, or appeal, just follow these steps:~~

~~Assistance~~

~~A toll free telephone number is available for a Covered Individual to obtain information about filing Grievances.~~

- ~~The individuals that answer the toll free telephone number can assist the caller or forward the call to the appropriate department if additional information is needed.~~

- Calls can be received at least 40 normal business hours per week and at other times the calls will be recorded by voicemail.
- If a call is left on voicemail, a qualified individual will respond to the call the next business day after the call is received.
- The calls will be answered by individuals who speak the English language. Non-English languages will be translated through a third party translation service.

Assistance is also available for Covered Individuals with literacy, physical, health, or other impediments.

Initial Utilization Review Determinations

Within 2 business days after receiving a request for a Utilization Review Determination that includes all information necessary to complete the Utilization Review Determination, we or a Utilization Review agent acting on our behalf, will notify the Covered Individual of the Utilization Review Determination by mail or another means of communication.

If the Utilization Review Determination does not certify an admission, a service, or a procedure, the notice will include:

- If the Utilization Review Determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination;
- The procedures to file a Grievance; and
- The toll free telephone number that the Covered Individual may call to request a review of the determination or obtain further information about the right to file a Grievance.

Internal Review of Grievances

Non-Urgent Care Review Request: A Covered Individual has 180 days following receipt of an initial notification of a determination to file a Grievance orally or in writing.

Urgent Care Review Request: Expedited reviews are available for Grievances regarding urgent care.

- **Acknowledgement:** An acknowledgement of the Grievance, given orally or in writing, must be provided by us within 5 business days after receipt of the Grievance. The notice must include:
- The name, address, and telephone number of an individual to contact regarding the Grievance; and
- The date the Grievance was filed.

Reviewer's Requirements:

- All Grievances regarding urgent care will be reviewed by a physician.
- A Grievance regarding appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a panel of one or more qualified individuals appointed by us.
  - The panel must include one or more individuals who:
    - Have knowledge of the medical condition, procedure, or treatment at issue;
    - Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment or service;
    - Were not involved in the original determination; and
    - Do not have a direct business relationship with the Covered Individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.

- The Covered Individual will be given the opportunity to appear in person before the panel or if unable to appear in person, otherwise appropriately communicate with the panel. The Covered Individual will be notified not less than 72 hours prior to the meeting of the panel.
- The panel will meet during normal business hours and at a place convenient to a Covered Individual who wishes to appear before or otherwise communicate with the panel.

- All other Grievances that are based in whole or in part on a medical judgment will be reviewed by a health care professional who has appropriate expertise in the field of medicine involved in the medical issue, was not involved in the original determination, and is not the subordinate of the original reviewer.
- If the Grievance concerns a Rescission action, a panel of individuals who were not involved in the original determination and who are not the subordinates of the original reviewer will review the Grievance.
- All other Grievances will be reviewed by an impartial person who was not involved in making the original determination, is not the subordinate of the original reviewer, and has sufficient experience, knowledge, and training to appropriately resolve the Grievance.

General Information:

- Covered Individuals have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
- Covered Individuals have the right to review the claim file and to present evidence and testimony as part of the internal review process.
- Covered Individuals may request reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge.
- All comments, documents, records and other information submitted by the Covered Individual relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial benefit determination, will be considered in the internal Grievance review.
- The Covered Individual will receive from us, as soon as possible, any new or additional evidence considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new information.
- The Covered Individual will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.
- A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.
- The internal appeal process must be exhausted before the Covered Individual may request an external review, unless:
  - The plan provides a waiver of this requirement;
  - The plan fails to follow the appeal process; or
  - The Covered Individual files an urgent care external appeal at the same time as an urgent care internal appeal.

- Resolution Timeframe:
- A Grievance regarding non-urgent care must be resolved as expeditiously as possible, reflecting the clinical urgency of the situation, but no later than:
  - 45 days after the Grievance regarding Post-service Claims is filed; or
  - 30 days after the Grievance regarding Pre-service Claims is filed.
- We will first orally notify the Covered Individual of the Grievance decision regarding urgent care within:
  - 48 hours after the Grievance regarding a Utilization Review Determination is filed and all the information necessary to complete the review is received, or 72 hours after the Grievance is received, whichever is earlier; or
  - 72 hours for all Grievances that are not regarding Utilization Review Determinations.
- The oral notification will be followed by a written notice as described in the Notification of Determination provision below.

Notification of Determination: We will notify a Covered Individual in writing of the resolution of the Grievance immediately for Grievances regarding Pre-service Claims or within 5 business days after completing an investigation of a Grievance regarding Post-service Claims. The notice must include:

- A statement of our understanding of the Covered Individual's Grievance;
- The decision reached by us;
- The contractual basis for the decision, including reference to specific plan provisions on which the determination is made;
- If applicable, the medical rationale for the resolution stated in sufficient detail for the Covered Individual to respond further to our position;
- Reference to the evidence or documentation used as the basis for the resolution, including a statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Individual's claim for benefits;
- The specific reason or reasons for the determination;
- A statement that the Covered Individual may have a right to bring a civil action under state or federal law;
- The specific rule, guideline, protocol, or other similar criterion, if used to make the determination, or that it will be provided free of charge upon request;
- The date of service;
- The health care provider's name;
- The claim amount;
- The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
- Our denial code with corresponding meaning;
- A description of any standard used, if any, in denying the claim;
- The department, address, and telephone number through which a Covered Individual may contact a qualified representative to obtain additional information about the decision or the next level of appeal available to them;

- If the Grievance is regarding appropriateness, medical necessity, experimental or investigational treatment or a Rescission:
  - Notice of the Covered Individual's right to external review by an independent review organization (IRO), including a description of the external review procedure; and
  - A copy of the Indiana Authorization Form which authorizes us to disclose protected health information for the external review; and
  - The plan must provide for the identification of medical experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the determination; and
- If applicable:
  - That assistance is available by contacting the specific state's consumer assistance department; and
  - A culturally linguistic statement based upon the Covered Individual's county or state of residence that provides for oral translation of the determination.

External Review

Non-Expedited Request:

- After exhausting the internal Grievance process, a Covered Individual has 120 days after notice of the second-level review resolution to request an external review in writing. A request for external review may only be made for a Grievance regarding:
  - A determination that a service or proposed service it not appropriate or Medically Necessary;
  - A determination that a service or proposed service is experimental or investigational; or
  - Our decision to Rescind an accident and sickness insurance policy.
- The Covered Individual is permitted to submit additional information regarding the proposed service throughout the external review process.
- The Covered Individual must sign an authorization form to release necessary medical information.

Expedited Request: An expedited request maybe made for Grievances related to a Sickness, disease, condition, Injury, or disability if the time frame for a standard review would seriously jeopardize the Covered Individual's:

- Life or health; or
- Ability to reach and maintain maximum function.

Procedure:

- When a request for external review is filed, we will:
  - Select an IRO from a list of IROs that are certified by the Department of Insurance (DOI); and
  - Rotate the choice of an IRO among all certified IROs before repeating a selection.
- We will cooperate with the IRO by promptly providing the IRO with any information requested by the IRO.
- If, at any time during an external review, the Covered Individual submits information to us that is relevant to our resolution and was not previously considered, we may reconsider the previous resolution.
  - The IRO will cease the external review process until the reconsideration is completed.

- We will notify the Covered Individual of the decision within 15 business days after the information is submitted (72 hours for an expedited review).
- If our decision is adverse to the Covered Individual, the Covered Individual may request that the IRO resume the external review.

- If we choose not to reconsider, we will forward the submitted information to the IRO within 2 business days after receipt.

Resolution Timeframe and Notification of Determination:

- The IRO will make a determination to uphold or reverse our determination within 15 business days (3 business days for expedited) after the request for external review is filed. The IRO will base their determination on information gathered from the Covered Individual or the Covered Individual's designee, us, and the treating health care provider, and any additional information that the IRO considers necessary and appropriate.
- The IRO will notify us and the Covered Individual of their determination within 72 hours (24 hours for expedited) of making the determination.

General Information:

- An external review decision is binding on us.
- We will pay for all costs of the external review by the IRO.

Definitions

As used in this section, the following terms have the meanings indicated.

Authorized Representative means:

- A person to whom a Covered Individual has given express written consent to represent the Covered Individual;
- A person authorized by law to provide substituted consent for a Covered Individual; or
- A family member of the Covered Individual or the Covered Individual's treating health care professional when the Covered Individual is unable to provide consent.

For purposes of these procedures, a reference to a Covered Individual may also refer to an Authorized Representative.

Covered Individual means an individual who is covered under an accident and sickness insurance policy. For purposes of these procedures, and where applicable, a Covered Individual may also include:

- An Authorized Representative of the Covered Individual; and
- A Provider Of Record acting on behalf of the Covered Individual.

Grievance means any dissatisfaction expressed by or on behalf of a Covered Individual regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is experimental or investigational;
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between:
  - A Covered Individual and us; or
  - A group policyholder and us; or
- Our decision to Rescind an accident and sickness insurance policy;

and for which the Covered Individual has a reasonable expectation that action will be taken to resolve or reconsider the matter than is the subject of dissatisfaction.

Notification Involving Urgent Care means a Grievance that meets any of the following conditions:

- The time periods for making non-urgent care review recommendations:
  - Could seriously jeopardize the life or health of the Covered Individual or the ability of the Covered Individual to regain maximum function; or
  - In the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
- Other than above, the decision as to whether a condition involves urgent care is to be determined by the attending provider, and we must defer to such determination of the attending provider.

Pre-service Claim means any claim for benefits for medical care or treatment that requires our approval in advance of the Covered Individual obtaining the medical care.

Provider Of Record means the physician or other licensed practitioner identified to a Utilization Review agent as having primary responsibility for the care, treatment, and services rendered to a Covered Individual.

Post-service Claim means any claim for benefits for medical care or treatment that is not a Pre-service Claim.

Rescind or **Rescission** means a cancellation or discontinuance of coverage by us that has a retroactive effect.

Utilization Review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a Covered Individual. The term does not include:

- Elective requests for clarification of coverage, eligibility, or benefits verification; or
- Medical claims review.

Utilization Review Determination means the rendering of a decision based on Utilization Review that denies or affirms either of the following:

- The necessity or appropriateness of the allocation of resources; or
- The provision or proposed provision of health care services to a Covered Individual.

The term does not include the identification of alternative, optional medical care that requires the approval of the Covered Individual and does not affect coverage or benefits if rejected by the Covered Individual.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.

- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us

includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

~~Interpretation of Benefits~~

~~We have the sole and exclusive authority to do all of the following:~~

- ~~Interpret Benefits under this Policy.~~
- ~~Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits* and any Riders and/or Amendments.~~
- ~~Make factual determinations related to this Policy and its Benefits.~~

~~We may delegate this authority to other persons or entities that provide services in regard to the administration of this Policy.~~

~~In certain circumstances, for purposes of overall cost savings or efficiency, we may, as we determine, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.~~

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.

- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.

- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.

- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

Individual Off-Exchange Qualified Health Plan Policy Amendment

All Savers Insurance Company

As described in this Amendment, the Qualified Health Plan Policy is modified to support coverage for Eligible Persons who wish to purchase the same Qualified Health Plan coverage off the individual exchange.

1. *Section 3: When Coverage Begins and Premiums* is replaced in its entirety with the following:

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete and submit an application for insurance and make the required Premium payment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

Who is eligible to enroll and who qualifies as a Dependent will be determined by us under the terms of this Policy.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules for coverage under this Policy and as determined based on information submitted in the application for coverage. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can apply for insurance for themselves and their Dependents, as determined by state or federal law.

Coverage begins on the date identified in this Policy if we receive the completed application and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by state or federal law.

Adding New Dependents

Policyholders may apply for insurance for Dependents only as described below.

The Policyholder must notify us of a new Dependent to be added to this Policy. Additional Premium may also be required, and it will be calculated from the date coverage is effective.

Dependent Eligibility

Your Dependents become eligible for insurance on the later of following:

- The date you became insured under this Policy.
- The first day of the first full calendar month after the date of becoming your Dependent.

Effective Date for Initial Dependents:

The effective date for your initial Dependents, if any, is shown on the face page of the Policy. Only Dependents included in the application for insurance will be covered on your effective date.

Adding a Newborn Child:

A Dependent child born to you or your spouse will be covered from the time of birth until the 31st day after birth, unless you or your spouse advises us not to add the newborn child.

Adding an Adopted Child:

A Dependent child legally placed for adoption with you or your spouse will be covered from the date of placement until the 31st day after placement, unless the placement is disrupted prior to legal adoption and the child is removed from your or your spouse's custody.

As used in this provision, "placement" means the earlier of the following:

- The date that you or your spouse assume physical custody of the child for the purpose of adoption.
- The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.

Additional Premium:

Additional Premium may be required to continue coverage beyond the 31st day following the birth or placement of the child. The required Premium will be calculated from the date of birth or date of placement for adoption. Coverage of the child will terminate on the 31st day following birth or placement,

unless we have received both written notice of the child's birth or your or your spouse's intent to adopt the child and the required premium within 90 days of the date of birth or date of placement.

Adding Other Dependents:

If you submit an application for insurance on a Dependent and you pay the required Premiums, then the effective date will be shown in the written notice to you that the Dependent is insured.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above~~., without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.~~

When adding a Dependent, Premiums shall be pro-rated based upon the effective date of the Dependent's coverage.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify us of your new residence. Your Premium will be based on your new residence beginning on the date determined by us. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

2. *Section 4: When Coverage Ends* is replaced in its entirety with the following:

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date we terminate as a Qualified Health Plan Issuer.
  - The date this benefit plan is decertified as a *Qualified Health Plan*.
  - The date we specify that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.

- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date you request if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy.

3. The definition of Eligible Person in *Section 8: Defined Terms* is replaced with the following:

Eligible Person - a person who meets the eligibility requirements for coverage under this Policy and as determined based on information submitted in the application. An Eligible Person must live within the Service Area.

_____

(Name and Title)

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 1200

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$1,200 per Covered Person, not to exceed $2,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.
Copayment	

Payment Term And Description	Amounts
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of	70%	Yes	Yes, after the Per Occurence Deductible of

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$250 per visit is satisfied ~~Yes~~
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70% ~~at a free-standing lab~~	Yes	Yes

Payment Term And Description		Amounts	
	~~50% at a Hospital-based lab~~	~~Yes~~	~~Yes~~
X-Ray and Other Diagnostic Testing - Outpatient:	70% ~~at a free-standing diagnostic center~~	Yes	Yes
	~~50% at an outpatient Hospital-based diagnostic center~~	~~Yes~~	~~Yes~~
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70% ~~at a free-standing diagnostic center~~	Yes	Yes
	~~70% at an outpatient Hospital-based diagnostic center~~	~~Yes~~	~~Yes~~
11. Mental Health Services			
	Inpatient 70%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $30 per visit	Yes	No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 70%	Yes	Yes

Payment Term And Description		Amounts	
	Outpatient 100% after you pay a Copayment of $30 per visit	Yes	No
13. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	70%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics -*	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No

Payment Term And Description		Amounts	
CT, PET, MRI, MRA and Nuclear Medicine - Outpatient. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	70%	Yes	Yes

Payment Term And Description		Amounts	
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of pulmonary therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	70%	Yes	Yes
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70% ~~at a free-standing center~~	Yes	Yes
	~~70% at an outpatient Hospital-based center~~	~~Yes~~	~~Yes, after the Per Occurence Deductible of $400 per date of service is satisfied~~

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Payment Term And Description		Amounts	
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
24. Surgery - Outpatient			
	~~70% at an ambulatory surgical center~~	~~Yes~~	~~Yes~~
	70% ~~at an outpatient Hospital-based surgical center~~	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes

Payment Term And Description		Amounts	
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
29. Autism Spectrum Disorders			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			

Payment Term And Description		Amounts	
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is

usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

~~Additional Network Availability~~

~~Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.~~

~~These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:~~

- ~~*Emergency Health Services – Outpatient*.~~
- ~~*Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.~~
- ~~Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.~~

~~Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.~~

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%
Space Maintainers (Spacers) ~~Limited to 1 per 60 months.~~	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy) ~~Limited to 1 time per tooth per lifetime.~~	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%
Adjunctive Services	
General Services (including Emergency Treatment)	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	66%
		2nd Tier Utilization:	34%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,500.00			$5,500.00
Coinsurance (%, Insurer's Cost Share)			70.00%			70.00%
OOP Maximum ($)			$6,600.00			$6,600.00
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	61.2%		☑	☑	61.2%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$35.00	☐	☐		$35.00
Specialist Visit	☐	☐		$75.00	☐	☐		$75.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$35.00	☐	☐		$35.00
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑	22.1%	
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100.0%	$0.00	☐	☐	100.0%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑	50.0%	
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑	59.7%	
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	61.4%		☑	☑	61.4%	
Preferred Brand Drugs	☑	☑	77.2%		☑	☑	77.2%	
Non-Preferred Brand Drugs	☑	☑	13.1%		☑	☑	13.1%	
Specialty Drugs (i.e. high-cost)	☑	☑	96.0%		☑	☑	96.0%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	66%
		2nd Tier Utilization:	34%

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	**Drug**	**Combined**	**Medical**	**Drug**	**Combined**
		$4,900.00			$4,900.00
		99.99%			99.99%
		$6,450.00			$6,450.00

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑	70.0%	
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100.0%	$0.00	☐	☐	100.0%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑	70.0%	
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑	70.0%	
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	61.4%		☑	☑	61.4%	
Preferred Brand Drugs	☑	☑	76.9%		☑	☑	76.9%	
Non-Preferred Brand Drugs	☑	☑	11.3%		☑	☑	11.3%	
Specialty Drugs (i.e. high-cost)	☑	☑	96.0%		☑	☑	96.0%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.3%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	66%
		2nd Tier Utilization:	34%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,250.00	$500.00		$1,250.00	$500.00	
Coinsurance (%, Insurer's Cost Share)	90.00%	90.00%		90.00%	90.00%	
OOP Maximum ($)	$6,600.00			$6,600.00		
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	76.9%		☑	☑	76.9%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☐	☐		$10.00
Specialist Visit	☐	☐		$30.00	☐	☐		$30.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☐	☐		$10.00
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑	56.9%	
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100.0%	$0.00	☐	☐	100.0%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑	70.0%	
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑	83.4%	
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$8.22	☐	☐		$8.22
Preferred Brand Drugs	☐	☐		$30.85	☐	☐		$30.85
Non-Preferred Brand Drugs	☑	☑	13.1%		☑	☑	13.1%	
Specialty Drugs (i.e. high-cost)	☑	☑	96.0%		☑	☑	96.0%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.4%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	66%
		2nd Tier Utilization:	34%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$500.00		$2,000.00	$500.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	70.00%		70.00%	70.00%	
OOP Maximum ($)	$6,600.00			$6,600.00		
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	60.7%		☑	☑	60.7%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		$30.00
Specialist Visit	☐	☐		$60.00	☐	☐		$60.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☐	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑	29.9%	
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100.0%	$0.00	☐	☐	100.0%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑	50.0%	
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑	61.7%	
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$13.52	☐	☐		$13.52
Preferred Brand Drugs	☐	☐		$39.16	☐	☐		$39.16
Non-Preferred Brand Drugs	☑	☑	3.7%		☑	☑	3.7%	
Specialty Drugs (i.e. high-cost)	☑	☑	95.9%		☑	☑	95.9%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.5%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	66%
		2nd Tier Utilization:	34%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$1,000.00		$3,500.00	$1,000.00	
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%		80.00%	80.00%	
OOP Maximum ($)	$6,600.00			$6,600.00		
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	69.4%		☑	☑	69.4%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☐	☐		$20.00
Specialist Visit	☐	☐		$60.00	☐	☐		$60.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$20.00	☐	☐		$20.00
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑	34.1%	
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100.0%	$0.00	☐	☐	100.0%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑	60.0%	
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑	70.6%	
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$8.53	☐	☐		$8.53
Preferred Brand Drugs	☐	☐		$34.23	☐	☐		$34.23
Non-Preferred Brand Drugs	☑	☑	8.9%		☑	☑	8.9%	
Specialty Drugs (i.e. high-cost)	☑	☑	96.1%		☑	☑	96.1%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	66%
		2nd Tier Utilization:	34%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$1,000.00		$5,000.00	$1,000.00	
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%		80.00%	80.00%	
OOP Maximum ($)	$6,600.00			$6,600.00		
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	69.4%		☑	☑	69.4%	
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☐	☐		$20.00
Specialist Visit	☐	☐		$40.00	☐	☐		$40.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$20.00	☐	☐		$20.00
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑	34.1%	
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100.0%	$0.00	☐	☐	100.0%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑	60.0%	
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑	70.6%	
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$8.84	☐	☐		$8.84
Preferred Brand Drugs	☐	☐		$37.61	☐	☐		$37.61
Non-Preferred Brand Drugs	☑	☑	8.9%		☑	☑	8.9%	
Specialty Drugs (i.e. high-cost)	☑	☑	95.9%		☑	☑	95.9%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.9%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☑
Annual Contribution Amount:		1st Tier Utilization:	66%
		2nd Tier Utilization:	34%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,600.00			$2,600.00
Coinsurance (%, Insurer's Cost Share)			99.99%			99.99%
OOP Maximum ($)			$6,450.00			$6,450.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑	70.0%	
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100.0%	$0.00	☐	☐	100.0%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑	70.0%	
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑	70.0%	
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	77.2%		☑	☑	77.2%	
Preferred Brand Drugs	☑	☑	80.6%		☑	☑	80.6%	
Non-Preferred Brand Drugs	☑	☑	7.6%		☑	☑	7.6%	
Specialty Drugs (i.e. high-cost)	☑	☑	96.2%		☑	☑	96.2%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.1%
Metal Tier:	Silver

All Savers Insurance Company

Choice Individual Medical Policy

[7440 Woodland Drive

Indianapolis, Indiana 46278-1719]

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if: (A) we do not receive premiums when due, as described in the Policy; (B) a Covered Person has committed an act of fraud or made an intentional misrepresentation in connection with the Policy; (C) we discontinue offering and refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live; or (D) we discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside. Please refer to Events Ending Your Coverage for further information.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

30-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 30 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, if any, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

- The study or investigation is conducted 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 clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits will also be provided for re-education or refresher training.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipmen*t. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug* subsection.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

5. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

11. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

~~12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services~~

~~Psychiatric services for Autism Spectrum Disorder that are both of the following:~~

- ~~Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.~~
- ~~Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.~~

~~This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.~~

~~Benefits include the following services provided on either an inpatient or outpatient basis:~~

- ~~Diagnostic evaluations and assessment.~~
- ~~Treatment planning.~~

- ~~Treatment and/or procedures.~~
- ~~Referral services.~~
- ~~Medication management.~~
- ~~Individual, family, therapeutic group and provider-based case management services.~~
- ~~Crisis intervention.~~
- ~~Partial Hospitalization/Day Treatment.~~
- ~~Intensive Outpatient Treatment.~~

~~Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).~~

~~The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.~~

~~We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.~~

~~13~~12. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

~~14~~13. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

~~15~~14. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

~~16~~15. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

~~17~~16. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on

how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

~~18~~17. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

~~19~~18. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

~~20~~19. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

~~21~~20. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

~~22~~21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

~~23~~22. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

~~24~~23. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

~~25~~24. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), chemotherapy (whether administered orally, intravenously, or by injection) or other intravenous infusion therapy and radiation oncology.

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

~~26~~25. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

~~27~~26. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

~~28~~27. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

~~29~~28. Autism Spectrum Disorder ~~Medical~~ Services

Benefits for Autism Spectrum Disorders will be ~~are~~ provided on the same basis as any other Sickness for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by ~~a~~ your treating Physician and approved by us.~~for the treatment of Autism Spectrum Disorder.~~ The written treatment plan provided by your Physician must include, but is not limited to: diagnosis, proposed treatment by type(s), frequency and duration of treatment(s), the anticipated outcomes stated as goals, and your Physician's signature. Our review of the proposed treatment plan will be by a specialist in the treatment of Autism Spectrum Disorders. If we deny the medical necessity of any service recommended by your Physician in the written treatment plan, you may appeal our decision by following the procedures detailed in *Section 6*.

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An~~y~~ exclusion within the Policy that is inconsistent with the approved treatment plan will ~~not apply.~~be waived to the extent of any conflict. We may require yourPhysician to submit an updated treatment plan every six months.

~~Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.~~

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

~~30~~29. Cancer Chemotherapy

Covered Health Services include chemotherapy for the treatment of cancer, whether administered orally, intravenously or by injection.

~~31~~30. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.

- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by dentures or bridges.

~~32~~31. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

~~33~~32. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

~~34~~33. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.

- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

~~35~~34. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

~~36~~35. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

~~37~~36. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay

for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

7. Any Dental Procedure not directly associated with dental disease.

8. Any Dental Procedure not performed in a dental setting.

9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.

16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.

17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

18. Foreign Services are not covered unless required as an Emergency.

19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).

- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

   Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

   - The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
   - The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

9. Any product dispensed for the purpose of appetite suppression or weight loss.

10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

12. Unit dose packaging or repackagers of Prescription Drug Products.

13. Medications used for cosmetic purposes.

14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.

15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

16. Prescription Drug Products when prescribed to treat infertility.

17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.

18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate

alternative. For information about this process, contact Customer Care at the telephone number on your ID card.

19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.

4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under ~~*Neurodevelopmental Disorders -*~~ *Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

    - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
    - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

J. 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 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.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.

- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist,

social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*

15. In vitro fertilization regardless of the reason for treatment.

M. 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 residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

4. The reversal of voluntary sterilization.

5. Fetal reduction surgery.

6. Abortion, except for Therapeutic Abortion.

O. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

P. 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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Q. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

R. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.

4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

U. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:

- Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
- Related to judicial or administrative proceedings or orders.
- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
- Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Subject to a determination of the Indiana Health Insurance Exchange, a newborn child of the Policyholder or the Policyholder's spouse will be covered from the time of birth until the 31st day after birth. Coverage will terminate on the 31st day following birth, unless we have received notice of the child's birth and any additional premium required. Coverage of the newborn child shall include coverage of Sickness and Injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including intpatient and outpatient expenses arising from medical and dental treatment involved in the management of cleft lip and cleft palate.

Subject to a determination of the Indiana Health Insurance Exchange, a child placed for adoption with the Policyholder or the Policyholder's spouse will be covered from the date of Placement until the 31st day following Placement unless the Placement is disrupted prior to legal adoption and the child is removed from the insured's custody. Coverage will terminate on the 31st day following Placement, unless we have received notice of the intent to adopt the child and any additional premium required.

"Placement" when used in reference to an adoption, means the earlier of:

- The date of placement for the purpose of adoption.
- The date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you or a third party identified above.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Time Limit on Certain Defenses

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent mistatements, made in the application for coverage shall be used to void the Policy or deny a claim for loss incurred after the expiration of this two year period.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Filing a Grievance

A grievance is any dissatisfaction expressed by, or on your behalf, regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Investigational Service
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between you and us; or
- Our decision to rescind the Policy

And for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

A grievance may be submitted orally or in writing. You or a person acting on your behalf may file a grievance.

The written request may be sent directly to us at the following address:

All Savers Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]

We will conduct a full and fair review of your grievance. The review of your grievance will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

We will acknowledge our receipt of your grievance, either orally or in writing, within 5 business days after receipt of the grievance. Grievances regarding appropriateness, medical necessity, or Experimental or Investigational Services will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination. All other grievances will be reviewed by at least one individual who:

- Was not involved in the making the original determination;
- Is not the subordinate of the original reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the grievance.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the grievance.

Grievance Determinations

For procedures associated with urgent requests for benefits, see Urgent Grievances that Require Immediate Action below.

You will be provided written or electronic notification of the decision as follows:

- For services not yet received:

- The grievance review will be resolved as quickly as possible but not more than 15 calendar days from receipt of a grievance of a denied request for benefits. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 15 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

- For all other grievances:
  - The grievance review will be resolved as quickly as possible, but not more than 20 business days after receiving all information reasonably necessary to complete the review. If we are unable to make a decision regarding the grievance within the 20 day period due to circumstances beyond our control, we will notify in writing before the 20th business day. We will then issue a written decision within a total of 30 calendar days after receipt of the grievance, regardless of whether all information has been received. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

Urgent Grievances that Require Immediate Action

Your grievance may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The grievance does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your grievance.

The grievance process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Internal Appeals Review

If you are not satisfied with the grievance decision, you have the right to appeal, orally or in writing, within 60 calendar days from your receipt of our grievance decision.

We will acknowledge our receipt of your appeal, either orally or in writing, within 5 business days after receipt of the appeal. If your appeal involves appropriateness, medical necessity, or experimental or investigational treatment, we will appoint a panel of one or more qualified individuals to resolve the appeal. The panel will include one or more individuals who:

- Have knowledge of the medical condition, procedure, or treatment at issue;
- Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
- Were not involved in the initial determination or the grievance review; and
- Do not have a direct business relationship with you or your provider who previously recommended the health care procedure, treatment, or service giving rise to the appeal.

You have the right to appear in person before the panel to present your case. If you are unable to appear in person, you have the right to otherwise appropriately communicate with the panel.

All other appeals of grievances that are based in whole or in part on a medical judgment will be reviewed in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination or the grievance review.
If the appeal concerns a rescission, a panel of individuals who were not involved in the original determination and who are not subordinates of the original reviewer will review the appeal.

All other appeals will be reviewed by an impartial person who:

- Was not involved in the making the original determination or the grievance review;
- Is not the subordinate of the original reviewer or the grievance reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the appeal.

The review of your appeal will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the appeal.

Appeal Determinations

For procedures associated with urgent requests for benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision as follows:

- For services not yet received:
  - An appeal of a grievance decision will be resolved as quickly as possible but not more than 15 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of5 business days after the investigation is complete or 15 calendar days after the appeal is received.
- For all other grievances :
  - An appeal of a grievance decision will be resolved as quickly as possible, but not more than 30 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the appeal is received.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal review process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

Please note that our decision is based only on whether or not benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your appeal.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review

If, after exhausting our internal review process, you are not satisfied with the decision made by us, you may be entitled to request an external review. You may request an external review of a grievance or appeal regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Iinvestigational Service; or
- Our decision to rescind your Policy.

An external review may be requested within 120 days after receipt of our appeal decision. You may request a standard external review by sending a written request to the address set out in the decision letter. If the grievance or appeal is related to an illness, disease, condition, injury, or a disability for which the time frame for a standard review would seriously jeopardize your life or health or you ability to reach and maintain maximum function, an expedited review will be allowed. An expedited external review may be requested by calling the toll-free number on your ID card or by sending a written request to the address set out in the decision letter.

We are responsible for selecting an IRO from the list of IROs that are certified by the State of Indiana Department of Insurance. A different IRO must be selected for each external review and we will not repeat a selection until all IROs have been used.

Reconsideration during the External Review Process

If, at any time during the external review process, you submit information to us that was not previously submitted for review, we have the right to reconsider our decision. At such time additional information is received and we wish to reconsider our decision, we shall notify the IRO and the external review will cease.

We will have 15 days to review the additional information and reconsider our decision. In the case of an expedited review, we will make a decision within 72 hours. We will notify you of our decision.

If we determine to uphold our original decision, you may request that the IRO resume the external review.

If we choose not to reconsider the additional information submitted, we will forward the information to the IRO within 2 business days of receipt of the information.

External Review Decision

In the case of a non-expedited review, the IRO's decision is to be made within 15 business days after the request is filed. The IRO is to notify us and you of the decision within 72 hours after making the decision.

An expedited review must be completed within 72 hours after all information is submitted to the IRO. The IRO is to notify us and you of the decision within 24 hours after making the decision.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of

providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes,

including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.

- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

~~**Autism Spectrum Disorder** - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.~~

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

State: Indiana **Filing Company:** All Savers Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Individual Health
Project Name/Number: IEXPOL.I.15.IN/IEXPOL.I.15.IN

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/01/2014		Form	Schedule of Benefits – Plan Gold Choice 1250 and Gold Choice 1250-1	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN G 1250.pdf (Superceded)
08/01/2014		Form	Schedule of Benefits – Plans Silver Choice 3500 and Silver Choice 3500-1	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S 3500.pdf (Superceded)
08/01/2014		Form	Schedule of Benefits – Plans Silver Choice 5000 and Silver Choice 5000-1	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S 5000.pdf (Superceded)
08/01/2014		Form	Schedule of Benefits – Plans Silver Choice 2000 and Silver 2000-1	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S 2000.pdf (Superceded)
08/01/2014		Form	Schedule of Benefits – Plan Silver Choice 2500	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S 2500.pdf (Superceded)
08/01/2014		Form	Schedule of Benefits – Plan Silver Choice 3500-2	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S 3500.pdf (Superceded)
08/01/2014		Form	Schedule of Benefits – Plan Silver Choice 1200	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S 1200.pdf (Superceded)
08/01/2014		Form	Schedule of Benefits – Plans Silver Choice 250, Silver Choice 250-1, and Silver Choice 250-2	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S 250.pdf (Superceded)
08/01/2014		Form	Schedule of Benefits – Plans Silver Choice 100, Silver Choice 100-1, and Silver Choice 100-2	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S 100.pdf (Superceded)
07/31/2014		Form	Policy	08/04/2014	IN IEX Policy Revised 073114 .pdf (Superceded)
07/31/2014		Form	Schedule of Benefits – Plans Silver Choice HSA 2600 and Silver Choice HSA 2600-1	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 2600 Aug 1.pdf (Superceded)

SERFF Tracking #: UHLC-129514067 **State Tracking #:** IEXPOL.I.15.IN **Company Tracking #:** IEXPOL.I.15.IN

State: Indiana **Filing Company:** All Savers Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Individual Health
Project Name/Number: IEXPOL.I.15.IN/IEXPOL.I.15.IN

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/31/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 1900	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 1900 Aug 1.pdf (Superceded)
07/31/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 550	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 550 Aug 1.pdf (Superceded)
07/31/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 75	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 75 Aug 1.pdf (Superceded)
07/31/2014		Form	Schedule of Benefits – Plans Bronze Choice HSA 4900 and Bronze Choice HSA 4900-1	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN B HSA 4900 Aug 1.pdf (Superceded)
07/31/2014		Form	Schedule of Benefits – Plans Bronze Choice 5500 and Bronze Choice 5500-1	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN B 5500 Aug 1.pdf (Superceded)
07/31/2014		Form	Schedule of Benefits – Plans, Gold Choice $0, Silver Choice HSA $0, Silver Choice $0, Silver Choice $0, Silver Choice $0, Bronze Choice HSA $0, and Bronze Choice $0	08/04/2014	FV4 - IN IEX Schedule SBN IEX CHC I 15 IN AI 0 Aug 1.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plans Silver Choice 3500 and Silver Choice 3500-1	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S 3500.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plans Silver Choice 5000 and Silver Choice 5000-1	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S 5000.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plan Silver Choice 2500	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S 2500.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plan Silver Choice 3500-2	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S 3500-2.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plans Silver Choice 2000 and Silver 2000-1	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S 2000.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plan Silver Choice 1200	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S 1200.pdf (Superceded)

SERFF Tracking #: UHLC-129514067 **State Tracking #:** IEXPOL.I.15.IN **Company Tracking #:** IEXPOL.I.15.IN

State: Indiana **Filing Company:** All Savers Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Individual Health
Project Name/Number: IEXPOL.I.15.IN/IEXPOL.I.15.IN

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/25/2014		Form	Schedule of Benefits – Plans Silver Choice 250, Silver Choice 250-1, and Silver Choice 250-2	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S 250.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plans Silver Choice 100, Silver Choice 100-1, and Silver Choice 100-2	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S 100.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plans Bronze Choice HSA 4900 and Bronze Choice HSA 4900-1	07/31/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN B HSA 4900.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plans Bronze Choice 5500 and Bronze Choice 5500-1	07/31/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN B 5500.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plans, Gold Choice $0, Silver Choice HSA $0, Silver Choice $0, Silver Choice $0, Silver Choice $0, Bronze Choice HSA $0, and Bronze Choice $0	07/31/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN AI 0.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 1900	07/31/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 1900.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 550	07/31/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 550.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 75	07/31/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 75.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plans Silver Choice HSA 2600 and Silver Choice HSA 2600-1	07/31/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN S HSA 2600.pdf (Superceded)
07/25/2014		Form	Policy	07/31/2014	IN IEX Policy Revised 072514.pdf (Superceded)
07/25/2014		Form	Schedule of Benefits – Plan Gold Choice 1250 and Gold Choice 1250-1	08/01/2014	FV3 - IN IEX Schedule SBN IEX CHC I 15 IN G 1250.pdf (Superceded)
06/19/2014		Form	Policy	07/25/2014	IN IEX Policy Revised 061014.pdf (Superceded)
06/19/2014		Form	Amendment-IEX-2015-Off Exchange-IN	07/25/2014	Amendment-IEX-2015-Off Exchange-IN.pdf (Superceded)

SERFF Tracking #: UHLC-129514067 **State Tracking #:** IEXPOL.I.15.IN **Company Tracking #:** IEXPOL.I.15.IN

State: Indiana **Filing Company:** All Savers Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Individual Health
Project Name/Number: IEXPOL.I.15.IN/IEXPOL.I.15.IN

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/11/2014		Rate	IN 2015 IEX Rate Manual	07/17/2014	3 - IN IEX 2015 Ratebook.pdf (Superceded)
05/30/2014		Form	Policy	06/19/2014	IN IEX Policy 5 30 14 Resubmission .pdf (Superceded)
05/09/2014		Supporting Document	Part III - Federal Actuarial Memorandum	06/11/2014	5 - IN IEX Part III Act Memo.pdf (Superceded) 12 - IN 2015 IEX Unique Plan Design Justification.pdf
05/09/2014		Rate	IN 2015 IEX Rate Manual	06/11/2014	3 - IN IEX 2015 Ratebook.pdf (Superceded)
05/09/2014		Supporting Document	Unified Rate Review Template	06/11/2014	4 - IN URRT Part I - values.xls (Superceded)
05/08/2014		Form	Amendment-IEX-2015-Off Exchange-IN	06/19/2014	15AMD-IEX-OX.IN, Amendment-IEX-2015-Off Exchange-IN.pdf (Superceded)
05/07/2014		Form	Policy	05/30/2014	IEXPOL.I.15.IN.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plan Gold Choice 1250 and Gold Choice 1250-1	07/25/2014	SBN IEX CHC I 15 IN G.1250.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans Silver Choice HSA 2600 and Silver Choice HSA 2600-1	07/25/2014	SBN IEX CHC I 15 IN S.HSA.2600.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 1900	07/25/2014	SBN IEX CHC I 15 IN S.HSA.1900.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 550	07/25/2014	SBN IEX CHC I 15 IN S.HSA.550.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plan Silver Choice HSA 75	07/25/2014	SBN IEX CHC I 15 IN S.HSA.75.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans Silver Choice 3500 and Silver Choice 3500-1	07/25/2014	SBN IEX CHC I 15 IN S.3500.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans Silver Choice 5000 and Silver Choice 5000-1	07/25/2014	SBN IEX CHC I 15 IN S.5000.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans Silver Choice 2000 and Silver 2000-1	07/25/2014	SBN IEX CHC I 15 IN S.2000.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plan Silver Choice 2500	07/25/2014	SBN IEX CHC I 15 IN S.2500.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plan Silver Choice 3500-2	07/25/2014	SBN IEX CHC I 15 IN S.3500-2.pdf (Superceded)

SERFF Tracking #: UHLC-129514067 **State Tracking #:** IEXPOL.I.15.IN **Company Tracking #:** IEXPOL.I.15.IN

State: Indiana **Filing Company:** All Savers Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Individual Health
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Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/07/2014		Form	Schedule of Benefits – Plan Silver Choice 1200	07/25/2014	SBN IEX CHC I 15 IN S.1200.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans Silver Choice 250, Silver Choice 250-1, and Silver Choice 250-2	07/25/2014	SBN IEX CHC I 15 IN S.250.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans Silver Choice 100, Silver Choice 100-1, and Silver Choice 100-2	07/25/2014	SBN IEX CHC I 15 IN S.100.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans Bronze Choice HSA 4900 and Bronze Choice HSA 4900-1	07/25/2014	SBN IEX CHC I 15 IN B HSA 4900.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans Bronze Choice 5500 and Bronze Choice 5500-1	07/25/2014	SBN IEX CHC I 15 IN B.5500.pdf (Superceded)
05/07/2014		Form	Schedule of Benefits – Plans, Gold Choice $0, Silver Choice HSA $0, Silver Choice $0, Silver Choice $0, Silver Choice $0, Bronze Choice HSA $0, and Bronze Choice $0	07/25/2014	SBN IEX CHC I 15 IN AI.0.pdf (Superceded)
04/24/2014		Supporting Document	4.1(A) QHP Individual New Rate/Form Requirements (Accident & Health)	06/11/2014	1 - IN IEX State Act Memo.pdf (Superceded)

SERFF Tracking #:	*UHLC-129514067*	***State Tracking #:***	*IEXPOL.I.15.IN*	***Company Tracking #:***	*IEXPOL.I.15.IN*

State:	*Indiana*	***Filing Company:***	*All Savers Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Individual Health*		
Project Name/Number:	*IEXPOL.I.15.IN/IEXPOL.I.15.IN*		

Attachment 4 - IN URRT Part I - values.xls is not a PDF document and cannot be reproduced here.

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Gold Choice 1250, Gold Choice 1250-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$1,250 per Covered Person, not to exceed $2,500 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Private Duty Nursing visits provided in a home setting are limited to 82 visits per year to a maximum of 164 visits per lifetime.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			

Payment Term And Description		Amounts	
Lab Testing - Outpatient:	90%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	90%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-**	90%	Yes	Yes

Payment Term And Description		Amounts	
Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services -*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $30 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Outpatient Therapy.			
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No ***No***	No No No
17. Prosthetic Devices			
	90%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	90%	Yes	Yes

Payment Term And Description		Amounts	
• 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	90%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	90%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.

Payment Term And Description		Amounts	
24. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Coverage for Dental			
	90%	Yes	Yes
28. Autism Spectrum Disorders			
	90%	Yes	Yes
29. Cancer Chemotherapy			
	90%	Yes	Yes

Payment Term And Description		Amounts	
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	90%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	90%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures,	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 3500, Silver Choice 3500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	80%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length		

Payment Term And Description	Amounts		
	of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	80%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	80%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a			

Payment Term And Description	Amounts		
pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
28. Autism Spectrum Disorders			
	80%	Yes	Yes
29. Cancer Chemotherapy			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	80%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures,	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 5000, Silver Choice 5000-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	80%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	80%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	80%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	80%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.

Payment Term And Description	Amounts		
24. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthetic/Hospital Charges for Dental Care			
	80%	Yes	Yes
28. Autism Spectrum Disorders			
	80%	Yes	Yes
29. Cancer Chemotherapy			
	80%	Yes	Yes

Payment Term And Description		Amounts	
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	80%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures,	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 2000, Silver Choice 2000-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$2,000 per Covered Person, not to exceed $4,000 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network**	70%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.

Payment Term And Description		Amounts	
provider and the amount we determine to be an Eligible Expense for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
X-Ray and Other Diagnostic Testing - Outpatient:	70% 70%	Yes Yes	Yes Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes

Payment Term And Description	Amounts		
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	70%	Yes	Yes
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist	Yes	No

Payment Term And Description	Amounts		
diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $60 per visit for services provided by any other Physician		
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No

Payment Term And Description		Amounts	
Breast pumps	100%	***No***	No
17. Prosthetic Devices			
	70%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	70%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes

Payment Term And Description	Amounts		
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
•	*Inpatient* 70%	Yes	Yes
•	*Outpatient* 100% after you pay a Copayment of $30 per visit	Yes	No
23. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered		

Payment Term And Description		Amounts	
do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
28. Autism Spectrum Disorders			
	70%	Yes	Yes
29. Cancer Chemotherapy			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes

Payment Term And Description	Amounts		
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale

currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based	

Payment Term And Description	Amounts
on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	70%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	70%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 2500

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$2,500 per Covered Person, not to exceed $5,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	80%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length		

Payment Term And Description	Amounts		
	of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	80%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	80%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a			

Payment Term And Description	Amounts		
pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
28. Autism Spectrum Disorders			
	80%	Yes	Yes
29. Cancer Chemotherapy			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	80%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures,	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 3500, Silver Choice 3500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	80%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length		

Payment Term And Description	Amounts		
	of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	80%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	80%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a			

Payment Term And Description	Amounts		
pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
28. Autism Spectrum Disorders			
	80%	Yes	Yes
29. Cancer Chemotherapy			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	80%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures,	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 1200

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$1,200 per Covered Person, not to exceed $2,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	70%	Yes	Yes, after the Per Occurence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	70%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	70%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	70%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	70%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes
20. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes

Payment Term And Description	Amounts		
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
28. Autism Spectrum Disorders			
	70%	Yes	Yes
29. Cancer Chemotherapy			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes

Payment Term And Description		Amounts	
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

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When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	70%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	70%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures,	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 250, Silver Choice 250-1, Silver Choice 250-2]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$250 per Covered Person, not to exceed $500 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $150 per visit is satisfied
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	90%	Yes	Yes

Payment Term And Description	Amounts		
X-Ray and Other Diagnostic Testing - Outpatient:	90%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	90%	Yes	Yes
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the	100% after you pay a Copayment of $10 per	Yes	No

Payment Term And Description		Amounts	
Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $30 per visit for services provided by any other Physician		
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		

Payment Term And Description		Amounts	
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100 100%	No No No	No No No
17. Prosthetic Devices			
	90%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	90%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes

Payment Term And Description	Amounts		
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	90%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization			

Payment Term And Description	Amounts		
and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	90%	Yes	Yes
28. Autism Spectrum Disorders			
	90%	Yes	Yes
29. Cancer Chemotherapy			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $250 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	90%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	90%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures,	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 100, Silver Choice 100-1, Silver Choice 100-2]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$100 per Covered Person, not to exceed $200 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$550 per Covered Person, not to exceed $1,100 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$150 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
X-Ray and Other Diagnostic Testing - Outpatient:	90% 90%	Yes Yes	Yes Yes

Payment Term And Description		Amounts	
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	 Yes Yes	 Yes No
12. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	90%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $20 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	90%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	90%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	90%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
23. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $200 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization			

Payment Term And Description	Amounts		
and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	90%	Yes	Yes
28. Autism Spectrum Disorders			
	90%	Yes	Yes
29. Cancer Chemotherapy			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $100 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	90%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	90%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures,	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice Individual Medical Policy

[7440 Woodland Drive

Indianapolis, Indiana 46278-1719]

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if: (A) we do not receive premiums when due, as described in the Policy; (B) a Covered Person has committed an act of fraud or made an intentional misrepresentation in connection with the Policy; (C) we discontinue offering and refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live; or (D) we discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside. Please refer to Events Ending Your Coverage for further information.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

30-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 30 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, if any, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

- The study or investigation is conducted 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 clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits will also be provided for re-education or refresher training.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipmen*t. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug* subsection.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

5. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

11. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

~~12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services~~

~~Psychiatric services for Autism Spectrum Disorder that are both of the following:~~

- ~~Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.~~
- ~~Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.~~

~~This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.~~

~~Benefits include the following services provided on either an inpatient or outpatient basis:~~

- ~~Diagnostic evaluations and assessment.~~
- ~~Treatment planning.~~

- ~~Treatment and/or procedures.~~
- ~~Referral services.~~
- ~~Medication management.~~
- ~~Individual, family, therapeutic group and provider-based case management services.~~
- ~~Crisis intervention.~~
- ~~Partial Hospitalization/Day Treatment.~~
- ~~Intensive Outpatient Treatment.~~

~~Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).~~

~~The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.~~

~~We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.~~

~~13~~12. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

~~14~~13. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

~~15~~14. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

~~16~~15. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

~~17~~16. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on

how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

~~18~~17. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

~~19~~18. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

~~20~~19. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

~~21~~20. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

~~22~~21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

~~23~~22. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

~~24~~23. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

~~25~~24. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), chemotherapy (whether administered orally, intravenously, or by injection) or other intravenous infusion therapy and radiation oncology.

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

~~26~~25. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

~~27~~26. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

~~28~~27. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

~~29~~28. Autism Spectrum Disorder ~~Medical~~ Services

Benefits for Autism Spectrum Disorders will be ~~are~~ provided on the same basis as any other Sickness for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by ~~a~~ your treating Physician and approved by us.~~for the treatment of Autism Spectrum Disorder.~~ The written treatment plan provided by your Physician must include, but is not limited to: diagnosis, proposed treatment by type(s), frequency and duration of treatment(s), the anticipated outcomes stated as goals, and your Physician's signature. Our review of the proposed treatment plan will be by a specialist in the treatment of Autism Spectrum Disorders. If we deny the medical necessity of any service recommended by your Physician in the written treatment plan, you may appeal our decision by following the procedures detailed in *Section 6*.

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An~~y~~ exclusion within the Policy that is inconsistent with the approved treatment plan will ~~not apply.~~be waived to the extent of any conflict. We may require yourPhysician to submit an updated treatment plan every six months.

~~Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.~~

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

~~30~~29. Cancer Chemotherapy

Covered Health Services include chemotherapy for the treatment of cancer, whether administered orally, intravenously or by injection.

~~31~~30. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.

- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by dentures or bridges.

~~32~~31. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

~~33~~32. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

~~34~~33. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.

- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

~~35~~34. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

~~36~~35. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

~~37~~36. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay

for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

7. Any Dental Procedure not directly associated with dental disease.

8. Any Dental Procedure not performed in a dental setting.

9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.

16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.

17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

18. Foreign Services are not covered unless required as an Emergency.

19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).

- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

   Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

   - The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
   - The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

9. Any product dispensed for the purpose of appetite suppression or weight loss.

10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

12. Unit dose packaging or repackagers of Prescription Drug Products.

13. Medications used for cosmetic purposes.

14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.

15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

16. Prescription Drug Products when prescribed to treat infertility.

17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.

18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate

alternative. For information about this process, contact Customer Care at the telephone number on your ID card.

19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.

4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under ~~*Neurodevelopmental Disorders -*~~ *Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

    - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
    - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

J. 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 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.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.

- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist,

social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*

15. In vitro fertilization regardless of the reason for treatment.

M. 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 residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

4. The reversal of voluntary sterilization.

5. Fetal reduction surgery.

6. Abortion, except for Therapeutic Abortion.

O. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

P. 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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Q. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

R. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.

4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

U. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:

- Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
- Related to judicial or administrative proceedings or orders.
- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
- Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Subject to a determination of the Indiana Health Insurance Exchange, a newborn child of the Policyholder or the Policyholder's spouse will be covered from the time of birth until the 31st day after birth. Coverage will terminate on the 31st day following birth, unless we have received notice of the child's birth and any additional premium required. Coverage of the newborn child shall include coverage of Sickness and Injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including intpatient and outpatient expenses arising from medical and dental treatment involved in the management of cleft lip and cleft palate.

Subject to a determination of the Indiana Health Insurance Exchange, a child placed for adoption with the Policyholder or the Policyholder's spouse will be covered from the date of Placement until the 31st day following Placement unless the Placement is disrupted prior to legal adoption and the child is removed from the insured's custody. Coverage will terminate on the 31st day following Placement, unless we have received notice of the intent to adopt the child and any additional premium required.

"Placement" when used in reference to an adoption, means the earlier of:

- The date of placement for the purpose of adoption.
- The date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you or a third party identified above.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Time Limit on Certain Defenses

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent mistatements, made in the application for coverage shall be used to void the Policy or deny a claim for loss incurred after the expiration of this two year period.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Filing a Grievance

A grievance is any dissatisfaction expressed by, or on your behalf, regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Investigational Service
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between you and us; or
- Our decision to rescind the Policy

And for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

A grievance may be submitted orally or in writing. You or a person acting on your behalf may file a grievance.

The written request may be sent directly to us at the following address:

All Savers Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]

We will conduct a full and fair review of your grievance. The review of your grievance will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

We will acknowledge our receipt of your grievance, either orally or in writing, within 5 business days after receipt of the grievance. Grievances regarding appropriateness, medical necessity, or Experimental or Investigational Services will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination. All other grievances will be reviewed by at least one individual who:

- Was not involved in the making the original determination;
- Is not the subordinate of the original reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the grievance.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the grievance.

Grievance Determinations

For procedures associated with urgent requests for benefits, see Urgent Grievances that Require Immediate Action below.

You will be provided written or electronic notification of the decision as follows:

- For services not yet received:

- The grievance review will be resolved as quickly as possible but not more than 15 calendar days from receipt of a grievance of a denied request for benefits. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 15 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

- For all other grievances:
  - The grievance review will be resolved as quickly as possible, but not more than 20 business days after receiving all information reasonably necessary to complete the review. If we are unable to make a decision regarding the grievance within the 20 day period due to circumstances beyond our control, we will notify in writing before the 20th business day. We will then issue a written decision within a total of 30 calendar days after receipt of the grievance, regardless of whether all information has been received. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

Urgent Grievances that Require Immediate Action

Your grievance may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The grievance does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your grievance.

The grievance process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Internal Appeals Review

If you are not satisfied with the grievance decision, you have the right to appeal, orally or in writing, within 60 calendar days from your receipt of our grievance decision.

We will acknowledge our receipt of your appeal, either orally or in writing, within 5 business days after receipt of the appeal. If your appeal involves appropriateness, medical necessity, or experimental or investigational treatment, we will appoint a panel of one or more qualified individuals to resolve the appeal. The panel will include one or more individuals who:

- Have knowledge of the medical condition, procedure, or treatment at issue;
- Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
- Were not involved in the initial determination or the grievance review; and
- Do not have a direct business relationship with you or your provider who previously recommended the health care procedure, treatment, or service giving rise to the appeal.

You have the right to appear in person before the panel to present your case. If you are unable to appear in person, you have the right to otherwise appropriately communicate with the panel.

All other appeals of grievances that are based in whole or in part on a medical judgment will be reviewed in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination or the grievance review.
If the appeal concerns a rescission, a panel of individuals who were not involved in the original determination and who are not subordinates of the original reviewer will review the appeal.

All other appeals will be reviewed by an impartial person who:

- Was not involved in the making the original determination or the grievance review;
- Is not the subordinate of the original reviewer or the grievance reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the appeal.

The review of your appeal will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the appeal.

Appeal Determinations

For procedures associated with urgent requests for benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision as follows:

- For services not yet received:
  - An appeal of a grievance decision will be resolved as quickly as possible but not more than 15 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of5 business days after the investigation is complete or 15 calendar days after the appeal is received.
- For all other grievances :
  - An appeal of a grievance decision will be resolved as quickly as possible, but not more than 30 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the appeal is received.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal review process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

Please note that our decision is based only on whether or not benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your appeal.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review

If, after exhausting our internal review process, you are not satisfied with the decision made by us, you may be entitled to request an external review. You may request an external review of a grievance or appeal regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Iinvestigational Service; or
- Our decision to rescind your Policy.

An external review may be requested within 120 days after receipt of our appeal decision. You may request a standard external review by sending a written request to the address set out in the decision letter. If the grievance or appeal is related to an illness, disease, condition, injury, or a disability for which the time frame for a standard review would seriously jeopardize your life or health or you ability to reach and maintain maximum function, an expedited review will be allowed. An expedited external review may be requested by calling the toll-free number on your ID card or by sending a written request to the address set out in the decision letter.

We are responsible for selecting an IRO from the list of IROs that are certified by the State of Indiana Department of Insurance. A different IRO must be selected for each external review and we will not repeat a selection until all IROs have been used.

Reconsideration during the External Review Process

If, at any time during the external review process, you submit information to us that was not previously submitted for review, we have the right to reconsider our decision. At such time additional information is received and we wish to reconsider our decision, we shall notify the IRO and the external review will cease.

We will have 15 days to review the additional information and reconsider our decision. In the case of an expedited review, we will make a decision within 72 hours. We will notify you of our decision.

If we determine to uphold our original decision, you may request that the IRO resume the external review.

If we choose not to reconsider the additional information submitted, we will forward the information to the IRO within 2 business days of receipt of the information.

External Review Decision

In the case of a non-expedited review, the IRO's decision is to be made within 15 business days after the request is filed. The IRO is to notify us and you of the decision within 72 hours after making the decision.

An expedited review must be completed within 72 hours after all information is submitted to the IRO. The IRO is to notify us and you of the decision within 24 hours after making the decision.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of

providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes,

including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.

- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

~~**Autism Spectrum Disorder** - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.~~

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice HSA 2600, Silver Choice HSA 2600-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$2,600 per Covered Person, not to exceed $5,200 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,450 per Covered Person, not to exceed $12,900 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense**	100%	Yes	Yes

Payment Term And Description	Amounts		
for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:	100%	Yes	Yes

Payment Term And Description	Amounts		
• Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
16. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No

Payment Term And Description		Amounts	
Breast pumps	100%	No	No
17. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
21. Skilled Nursing Facility/Inpatient			

Payment Term And Description		Amounts	
Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	100%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
23. Surgery - Outpatient			
	100%	Yes	Yes
24. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization			

Payment Term And Description	Amounts		
and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental			
	100%	Yes	Yes
28. Autism Spectrum Disorders			
	100%	Yes	Yes
29. Cancer Chemotherapy			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes

Payment Term And Description	Amounts		
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale

currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is

available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 1900

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.	$1,900 per Covered Person, not to exceed $3,800 for all Covered Persons

Payment Term And Description	Amounts
Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
• Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**

Payment Term And Description		Amounts	
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**]	100%	Yes	Yes

Payment Term And Description	Amounts		
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described	100%	Yes	Yes

Payment Term And Description	Amounts		
under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
16. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No

Payment Term And Description		Amounts	
Breast pumps	100%	No	No
17. Prosthetic Devices			
	100%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled	100%	Yes	Yes

Payment Term And Description		Amounts	
Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.			
22. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
23. Surgery - Outpatient			
	100%	Yes	Yes
24. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Payment Term And Description	Amounts		
cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.			
26. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	100%	Yes	Yes
28. Autism Spectrum Disorders			
	100%	Yes	Yes
29. Cancer Chemotherapy			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			

Payment Term And Description		Amounts	
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale

currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 550

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$550 per Covered Person, not to exceed $1,100 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network**	100%	Yes	Yes

Payment Term And Description		Amounts	
provider and the amount we determine to be an Eligible Expense for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
12. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:	100%	Yes	Yes

Payment Term And Description	Amounts		
• Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
16. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No

Payment Term And Description	Amounts		
Breast pumps	100%	No	No
17. Prosthetic Devices			
	100%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
21. Skilled Nursing Facility/Inpatient			

Payment Term And Description		Amounts	
Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
23. Surgery - Outpatient			
	100%	Yes	Yes
24. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Payment Term And Description	Amounts		
cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.			
26. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	100%	Yes	Yes
28. Autism Spectrum Disorders			
	100%	Yes	Yes
29. Cancer Chemotherapy			
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			

Payment Term And Description		Amounts	
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at

[www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is

available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	100%
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to 1 time per 60 months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 75

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$75 per Covered Person, not to exceed $150 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	Yes	Yes

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for**	100%	Yes	Yes

Payment Term And Description		Amounts	
any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes

Payment Term And Description	Amounts		
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
16. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
17. Prosthetic Devices			
	100%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	100%	Yes	Yes

Payment Term And Description	Amounts		
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
23. Surgery - Outpatient			
	100%	Yes	Yes
24. Therapeutic Treatments - Outpatient			

Payment Term And Description		Amounts	
	100%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthetic/Hospital Charges for Dental Care			
	100%	Yes	Yes
28. Autism Spectrum Disorders			
	100%	Yes	Yes
29. Cancer Chemotherapy			
30. Dental Services - Accident Only			
	100%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Bronze Choice HSA 4900, Bronze Choice HSA 4900-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$4,900 per Covered Person, not to exceed $9,800 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,450 per Covered Person, not to exceed $12,900 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100% *Air or Water Ambulance:* 100%	Yes Yes	Yes Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100% *Air or Water Ambulance:* 100%	Yes Yes	Yes Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	Yes	Yes

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length		

Payment Term And Description	Amounts		
	of stay.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	100%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes

Payment Term And Description	Amounts		
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	100%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
23. Surgery - Outpatient			
	100%	Yes	Yes
24. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			

Payment Term And Description		Amounts	
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Coverage for Dental			
	100%	Yes	Yes
28. Autism Spectrum Disorders			
	100%	Yes	Yes
29. Cancer Chemotherapy			
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			

Payment Term And Description		Amounts	
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at

[www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery ***(Subject to payment of the Annual Deductible.)***	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	100%
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Bronze Choice 5500, Bronze Choice 5500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$5,500 per Covered Person, not to exceed $11,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70% *Air or Water Ambulance:* 70%	Yes Yes	Yes Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70% *Air or Water Ambulance:* 70%	Yes Yes	Yes Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	70%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	70%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $35 per visit	Yes Yes	Yes No
12. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
13 Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to**	70%	Yes	Yes

Payment Term And Description		Amounts	
obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $35 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $75 per visit for services provided by any other Physician	Yes	No
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			

Payment Term And Description		Amounts	
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No ***No***	No No No
17. Prosthetic Devices			
	70%	Yes	Yes
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient	70%	Yes	Yes

Payment Term And Description	Amounts		
rehabilitation)			
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	70%	Yes	Yes
22. Substance-Related and Addictive Disorders Services			
•	*Inpatient* 70%	Yes	Yes
•	*Outpatient* 100% after you pay a Copayment of $35 per visit	Yes	No
23. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $500 per visit is satisfied.
24. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes

Payment Term And Description		Amounts	
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
28. Autism Spectrum Disorders			
	70%	Yes	Yes
29. Cancer Chemotherapy			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	70%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	70%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures,	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Gold Choice $0, Silver Choice $0, Bronze Choice $0, Silver Choice HSA $0, Bronze Choice HSA $0]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	No Annual Deductible
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$0 per Covered Person
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of:	

Payment Term And Description	Amounts
• The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	No	No
	Air or Water Ambulance: 100%	No	No
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	No	No
	Air or Water Ambulance: 100%	No	No

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and *Outpatient Prescription Drugs.* Benefits for diabetes supplies will be the same as those stated under *Outpatient Prescription Drugs*.		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	No	No
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	No	No

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	No	No
7. Hospice Care			
	100%	No	No
8. Hospital - Inpatient Stay			
	100%	No	No
9. Lab, X-Ray and Diagnostics - Outpatient			

Payment Term And Description		Amounts	
Lab Testing - Outpatient:	100%	No	No
X-Ray and Other Diagnostic Testing - Outpatient:	100%	No	No
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	No	No
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	No No	No No
12. Pharmaceutical Products - Outpatient			
	100%	No	No
13. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be**	100%	No	No

Payment Term And Description	Amounts		
an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
14. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	No	No

Payment Term And Description	Amounts		
15. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
16. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
17. Prosthetic Devices			
	100%	No	No
18. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
19. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive	100%	No	No

Payment Term And Description		Amounts	
rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
20. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	No	No
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	No	No
22. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	No No	No No
23. Surgery - Outpatient			
	100%	No	No

Payment Term And Description	Amounts		
24. Therapeutic Treatments - Outpatient			
	100%	No	No
25. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
26. Urgent Care Center Services			
	100%	No	No
Additional Benefits Required By Indiana Law			
27. Anesthesia/Hospital Charges for Dental Care			
	100%	No	No
28. Autism Spectrum Disorders			
	100%	No	No
29. Cancer Chemotherapy			

Payment Term And Description		Amounts	
	100%	No	No
30. Dental Services - Accident Only			
	100%	No	No
31. Inherited Metabolic Disease			
	100%	No	No
32. Orthotic Devices			
	100%	No	No
33. Ostomy Supplies			
	100%	No	No
34. TMJ			
	100%	No	No
35. Vision Correction Following Injury/Surgery			
	100%	No	No
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	No	No

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

This exception for laboratory services and durable medical equipment will not apply to services and equipment that are billed directly by the Network facility.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	No Copayment

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 4 times per 12 months (when combined with *Periodontal Maintenance*).	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period (when combined with *Dental Prophylaxis*) following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		100% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 3500, Silver Choice 3500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described	80%	Yes	Yes

Payment Term And Description		Amounts	
below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	80%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy.	80%	Yes	Yes

Payment Term And Description	Amounts		
• 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
24. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.

Payment Term And Description		Amounts	
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
29. Autism Spectrum Disorders			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
32. Ostomy Supplies			
	80%	Yes	Yes
33. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 5000, Silver Choice 5000-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network	80%	Yes	Yes

Payment Term And Description		Amounts	
facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
• Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	80%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear	80%	Yes	Yes

Payment Term And Description	Amounts		
implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	80%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthetic/Hospital Charges for Dental Care			
	80%	Yes	Yes

Payment Term And Description	Amounts		
29. Autism Spectrum Disorders			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible

Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 2500

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$2,500 per Covered Person, not to exceed $5,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description	Amounts		
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described	80%	Yes	Yes

Payment Term And Description		Amounts	
below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	80%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy.	80%	Yes	Yes

Payment Term And Description	Amounts		
• 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
24. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.

Payment Term And Description		Amounts	
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
29. Autism Spectrum Disorders			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 3500-2

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	80%	Yes	Yes, after the Per Occurrence

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-**	80%	Yes	Yes

Payment Term And Description		Amounts	
Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services -*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Outpatient Therapy.			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	80%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive	80%	Yes	Yes

Payment Term And Description	Amounts		
rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	80%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
24. Surgery - Outpatient			
	80%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.

Payment Term And Description		Amounts	
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthetic/Hospital Charges for Dental Care			
	80%	Yes	Yes
29. Autism Spectrum Disorders			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $750 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug	

Payment Term And Description	Amounts
Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	80%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy)	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 2000, Silver Choice 2000-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$2,000 per Covered Person, not to exceed $4,000 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network**	70%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.

Payment Term And Description		Amounts	
provider and the amount we determine to be an Eligible Expense for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
X-Ray and Other Diagnostic Testing - Outpatient:	70% 70%	Yes Yes	Yes Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 70%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $30 per visit	Yes	No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 70%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $30 per visit	Yes	No
13. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	70%	Yes	Yes

Payment Term And Description		Amounts	
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			

Payment Term And Description	Amounts		
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No ***No***	No No No
18. Prosthetic Devices			
	70%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days	70%	Yes	Yes

Payment Term And Description	Amounts		
(when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
•	*Inpatient* 70%	Yes	Yes
•	*Outpatient* 100% after you pay a Copayment of $30 per visit	Yes	No
24. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes

Payment Term And Description	Amounts		
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
29. Autism Spectrum Disorders			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes

Payment Term And Description		Amounts	
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.

- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based	

Payment Term And Description	Amounts
on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	70%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	70%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice 1200

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$1,200 per Covered Person, not to exceed $2,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	70%	Yes	Yes, after the Per Occurence

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $250 per visit is satisfied
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70%	Yes	Yes

Payment Term And Description	Amounts		
X-Ray and Other Diagnostic Testing - Outpatient:	70%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described	70%	Yes	Yes

Payment Term And Description		Amounts	
below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	70%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy.	70%	Yes	Yes

Payment Term And Description	Amounts		
• 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No
24. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.

Payment Term And Description	Amounts		
25. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
29. Autism Spectrum Disorders			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes

Payment Term And Description		Amounts	
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	70%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 250, Silver Choice 250-1, Silver Choice 250-2]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$250 per Covered Person, not to exceed $500 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurence

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			Deductible of $150 per visit is satisfied
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	90%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	90%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-**	90%	Yes	Yes

Payment Term And Description		Amounts	
Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $30 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100 100%	No No No	No No No
18. Prosthetic Devices			
	90%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	90%	Yes	Yes

Payment Term And Description	Amounts		
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	90%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
24. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.

Payment Term And Description		Amounts	
25. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	90%	Yes	Yes
29. Autism Spectrum Disorders			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	90%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $250 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	90%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	90%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice 100, Silver Choice 100-1, Silver Choice 100-2]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$100 per Covered Person, not to exceed $200 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$550 per Covered Person, not to exceed $1,100 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description		Amounts	
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$150 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
X-Ray and Other Diagnostic Testing - Outpatient:	90% 90%	Yes Yes	Yes Yes

Payment Term And Description		Amounts	
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	 Yes Yes	 Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	 Yes Yes	 Yes No
13. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for**	90%	Yes	Yes

Payment Term And Description		Amounts	
any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $20 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	90%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	90%	Yes	Yes

Payment Term And Description	Amounts		
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	90%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
24. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $200 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes

Payment Term And Description	Amounts		
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	90%	Yes	Yes
29. Autism Spectrum Disorders			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes
32. Orthotic Devices			

Payment Term And Description		Amounts	
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is

usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $100 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%
Space Maintainers (Spacers) Benefit includes all adjustments	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Bronze Choice HSA 4900, Bronze Choice HSA 4900-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$4,900 per Covered Person, not to exceed $9,800 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,450 per Covered Person, not to exceed $12,900 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100% *Air or Water Ambulance:* 100%	Yes Yes	Yes Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100% *Air or Water Ambulance:* 100%	Yes Yes	Yes Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	Yes	Yes

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this	100%	Yes	Yes

Payment Term And Description	Amounts		
Schedule of Benefits. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services -*	100%	Yes	Yes

Payment Term And Description	Amounts		
Outpatient Therapy.			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	100%	Yes	Yes

Payment Term And Description	Amounts		
• 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
24. Surgery - Outpatient			
	100%	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes

Payment Term And Description	Amounts		
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Coverage for Dental			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes

Payment Term And Description		Amounts	
31. Ostomy Supplies			
	100%	Yes	Yes
32. TMJ			
	100%	Yes	Yes
33. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
34. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at

[www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery ***(Subject to payment of the Annual Deductible.)***	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Bronze Choice 5500, Bronze Choice 5500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$5,500 per Covered Person, not to exceed $11,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70% *Air or Water Ambulance:* 70%	Yes Yes	Yes Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70% *Air or Water Ambulance:* 70%	Yes Yes	Yes Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	70%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	70%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70%	Yes	Yes
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $35 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
•	*Inpatient* 70% *Outpatient* 100% after you pay a Copayment of $35 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes

Payment Term And Description	Amounts		
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	70%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.*	100% after you pay a Copayment of $35 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $75 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No ***No***	No No No
18. Prosthetic Devices			
	70%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy.	70%	Yes	Yes

Payment Term And Description	Amounts		
• 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	70%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
•	*Inpatient* 70%	Yes	Yes
•	*Outpatient* 100% after you pay a Copayment of $35 per visit	Yes	No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	70%	Yes	Yes, after the Per Occurrence Deductible of $500 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes

Payment Term And Description	Amounts		
29. Autism Spectrum Disorders			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible

Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	70%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy)	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Gold Choice $0, Silver Choice $0, Bronze Choice $0, Silver Choice HSA $0, Bronze Choice HSA $0]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	No Annual Deductible
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$0 per Covered Person
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of:	

Payment Term And Description	Amounts
• The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	No	No
	Air or Water Ambulance: 100%	No	No
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	No	No
	Air or Water Ambulance: 100%	No	No

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and *Outpatient Prescription Drugs.* Benefits for diabetes supplies will be the same as those stated under *Outpatient Prescription Drugs*.		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	No	No
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	No	No

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	No	No
7. Hospice Care			
	100%	No	No
8. Hospital - Inpatient Stay			
	100%	No	No
9. Lab, X-Ray and Diagnostics - Outpatient			

Payment Term And Description		Amounts	
Lab Testing - Outpatient:	100%	No	No
X-Ray and Other Diagnostic Testing - Outpatient:	100%	No	No
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	No	No
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	No No	No No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	No No	No No
13. Pharmaceutical Products - Outpatient			
	100%	No	No
14. Physician Fees for Surgical and Medical Services			

Payment Term And Description		Amounts	
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	No	No
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.*	100%	No	No

Payment Term And Description		Amounts	
• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	No	No
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy.	100%	No	No

Payment Term And Description		Amounts	
• 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	No	No
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	No	No
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	No No	No No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	100%	No	No
25. Therapeutic Treatments - Outpatient			
	100%	No	No
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	No	No
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	No	No

Payment Term And Description	Amounts		
29. Autism Spectrum Disorders			
	100%	No	No
30. Dental Services - Accident Only			
	100%	No	No
31. Inherited Metabolic Disease			
	100%	No	No
32. Orthotic Devices			
	100%	No	No
33. Ostomy Supplies			
	100%	No	No
34. TMJ			
	100%	No	No
35. Vision Correction Following Injury/Surgery			
	100%	No	No
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	No	No

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible

Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	No Copayment

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		100% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 1900

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.	$1,900 per Covered Person, not to exceed $3,800 for all Covered Persons

Payment Term And Description	Amounts
Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
• Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**

Payment Term And Description		Amounts	
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**]	100%	Yes	Yes

Payment Term And Description	Amounts		
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
15. Physician's Office Services -			

Payment Term And Description		Amounts	
Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes

Payment Term And Description	Amounts		
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
24. Surgery - Outpatient			
	100%	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes

Payment Term And Description	Amounts		
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.

- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 550

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$550 per Covered Person, not to exceed $1,100 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network**	100%	Yes	Yes

Payment Term And Description		Amounts	
provider and the amount we determine to be an Eligible Expense for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes

Payment Term And Description		Amounts	
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			

Payment Term And Description	Amounts		
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient	100%	Yes	Yes

Payment Term And Description		Amounts	
rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
24. Surgery - Outpatient			
	100%	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes

Payment Term And Description	Amounts		
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes

Payment Term And Description	Amounts		
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.

- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

UnitedHealthcare Silver Choice HSA 75

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits	$75 per Covered Person, not to exceed $150 for all Covered Persons in a family.

Payment Term And Description	Amounts
used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	100%	Yes	Yes

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes

Payment Term And Description		Amounts	
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*	100%	Yes	Yes

Payment Term And Description	Amounts		
• Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy.	100%	Yes	Yes

Payment Term And Description	Amounts		
• 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	100%	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthetic/Hospital Charges for Dental Care			
	100%	Yes	Yes

Payment Term And Description	Amounts		
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible

Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Silver Choice HSA 2600, Silver Choice HSA 2600-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$2,600 per Covered Person, not to exceed $5,200 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,450 per Covered Person, not to exceed $12,900 for all Covered Persons in a family.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense**	100%	Yes	Yes

Payment Term And Description	Amounts		
for reimbursement.			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes

Payment Term And Description		Amounts	
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100%	Yes	Yes
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that		

Payment Term And Description	Amounts		
	an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	Yes	Yes

Payment Term And Description	Amounts		
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
24. Surgery - Outpatient			
	100%	Yes	Yes

Payment Term And Description		Amounts	
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes

Payment Term And Description	Amounts		
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates

allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy)	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice Individual Medical Policy

[7440 Woodland Drive

Indianapolis, Indiana 46278-1719]

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if: (A) we do not receive premiums when due, as described in the Policy; (B) a Covered Person has committed an act of fraud or made an intentional misrepresentation in connection with the Policy; (C) we discontinue offering and refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live; or (D) we discontinue offering and refuse to renew all individal policies/certificates in the individual market in the state where you reside. Please refer to Events Ending Your Coverage for further information.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

30-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 30 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, if any, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

- The study or investigation is conducted 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 clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits will also be provided for re-education or refresher training.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipmen*t. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug* subsection.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

5. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

11. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorder that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.

- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

13. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

14. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

15. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

16. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

17. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on

how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

18. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

19. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

20. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

21. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

23. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

24. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

25. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), chemotherapy (whether administered orally, intravenously, or by injection) or other intravenous infusion therapy and radiation oncology.

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

26. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

27. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

28. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

29. Autism Spectrum Disorder Medical Services

Benefits are provided on the same basis as any other Sickness for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by a treating Physician for the treatment of Autism Spectrum Disorder. Any exclusion within the Policy that is inconsistent with the treatment plan will not apply.

Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

30. Cancer Chemotherapy

Covered Health Services include chemotherapy for the treatment of cancer, whether administered orally, intravenously or by injection.

31. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by dentures or bridges.

32. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

33. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

34. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

35. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

36. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

37. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health

management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly associated with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA)*

Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).

- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.

- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
    - Extraction, restoration and replacement of teeth.
    - Medical or surgical treatments of dental conditions.
    - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
    - Blood pressure cuff/monitor.
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

- The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
- The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.
18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.
19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
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 may be made up to six times during a calendar

year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

    - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
    - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

J. 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 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.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive

if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
15. In vitro fertilization regardless of the reason for treatment.

M. 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 residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Fetal reduction surgery.
6. Abortion, except for Therapeutic Abortion.

O. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

P. 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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.

6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Q. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

R. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

U. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - ♦ Medically Necessary.
    - ♦ Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - ♦ Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:
    - ▪ Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - ▪ Related to judicial or administrative proceedings or orders.
    - ▪ Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
    - ▪ Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.

5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.

6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

9. Autopsy.

10. Foreign language and sign language services.

11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Subject to a determination of the Indiana Health Insurance Exchange, a newborn child of the Policyholder or the Policyholder's spouse will be covered from the time of birth until the 31st day after birth. Coverage will terminate on the 31st day following birth, unless we have received notice of the child's birth and any additional premium required. Coverage of the newborn child shall include coverage of Sickness and Injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including intpatient and outpatient expenses arising from medical and dental treatment involved in the management of cleft lip and cleft palate.

Subject to a determination of the Indiana Health Insurance Exchange, a child placed for adoption with the Policyholder or the Policyholder's spouse will be covered from the date of Placement until the 31st day following Placement unless the Placement is disrupted prior to legal adoption and the child is removed from the insured's custody. Coverage will terminate on the 31st day following Placement, unless we have received notice of the intent to adopt the child and any additional premium required.

"Placement" when used in reference to an adoption, means the earlier of:

- The date of placement for the purpose of adoption.
- The date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you or a third party identified above.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Time Limit on Certain Defenses

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent mistatements, made in the application for coverage shall be used to void the Policy or deny a claim for loss incurred after the expiration of this two year period.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Filing a Grievance

A grievance is any dissatisfaction expressed by, or on your behalf, regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Investigational Service
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between you and us; or
- Our decision to rescind the Policy

And for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

A grievance may be submitted orally or in writing. You or a person acting on your behalf may file a grievance.

The written request may be sent directly to us at the following address:

All Savers Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]

We will conduct a full and fair review of your grievance. The review of your grievance will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

We will acknowledge our receipt of your grievance, either orally or in writing, within 5 business days after receipt of the grievance. Grievances regarding appropriateness, medical necessity, or Experimental or Investigational Services will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination. All other grievances will be reviewed by at least one individual who:

- Was not involved in the making the original determination;
- Is not the subordinate of the original reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the grievance.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the grievance.

Grievance Determinations

For procedures associated with urgent requests for benefits, see Urgent Grievances that Require Immediate Action below.

You will be provided written or electronic notification of the decision as follows:

- For services not yet received:

- The grievance review will be resolved as quickly as possible but not more than 15 calendar days from receipt of a grievance of a denied request for benefits. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 15 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

- For all other grievances:
  - The grievance review will be resolved as quickly as possible, but not more than 20 business days after receiving all information reasonably necessary to complete the review. If we are unable to make a decision regarding the grievance within the 20 day period due to circumstances beyond our control, we will notify in writing before the 20th business day. We will then issue a written decision within a total of 30 calendar days after receipt of the grievance, regardless of whether all information has been received. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the grievance is received. If you are not satisfied with the grievance decision, you have the right to appeal.

Urgent Grievances that Require Immediate Action

Your grievance may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The grievance does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your grievance.

The grievance process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Internal Appeals Review

If you are not satisfied with the grievance decision, you have the right to appeal, orally or in writing, within 60 calendar days from your receipt of our grievance decision.

We will acknowledge our receipt of your appeal, either orally or in writing, within 5 business days after receipt of the appeal. If your appeal involves appropriateness, medical necessity, or experimental or investigational treatment, we will appoint a panel of one or more qualified individuals to resolve the appeal. The panel will include one or more individuals who:

- Have knowledge of the medical condition, procedure, or treatment at issue;
- Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
- Were not involved in the initial determination or the grievance review; and
- Do not have a direct business relationship with you or your provider who previously recommended the health care procedure, treatment, or service giving rise to the appeal.

You have the right to appear in person before the panel to present your case. If you are unable to appear in person, you have the right to otherwise appropriately communicate with the panel.

All other appeals of grievances that are based in whole or in part on a medical judgment will be reviewed in consultation with a health care professional with appropriate expertise in the field, who was not involved in the initial determination or the grievance review.
If the appeal concerns a rescission, a panel of individuals who were not involved in the original determination and who are not subordinates of the original reviewer will review the appeal.

All other appeals will be reviewed by an impartial person who:

- Was not involved in the making the original determination or the grievance review;
- Is not the subordinate of the original reviewer or the grievance reviewer; and
- Has sufficient experience, knowledge, and training to appropriately resolve the appeal.

The review of your appeal will take into account all comments, documents, records, and other information submitted by you or a person acting on your behalf, whether or not it was submitted or considered during the initial benefit determination.

Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the appeal.

Appeal Determinations

For procedures associated with urgent requests for benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision as follows:

- For services not yet received:
  - An appeal of a grievance decision will be resolved as quickly as possible but not more than 15 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of5 business days after the investigation is complete or 15 calendar days after the appeal is received.
- For all other grievances :
  - An appeal of a grievance decision will be resolved as quickly as possible, but not more than 30 calendar days after receipt of the appeal. We will notify you in writing of the resolution the earlier of 5 business days after the investigation is complete or 30 calendar days after the appeal is received.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal review process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

Please note that our decision is based only on whether or not benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the telephone number shown on your ID card.
- The review will be conducted by a Physician.
- We will provide you with an oral determination within 48 hours following receipt of your appeal.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review

If, after exhausting our internal review process, you are not satisfied with the decision made by us, you may be entitled to request an external review. You may request an external review of a grievance or appeal regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is an Experimental or Iinvestigational Service; or
- Our decision to rescind your Policy.

An external review may be requested within 120 days after receipt of our appeal decision. You may request a standard external review by sending a written request to the address set out in the decision letter. If the grievance or appeal is related to an illness, disease, condition, injury, or a disability for which the time frame for a standard review would seriously jeopardize your life or health or you ability to reach and maintain maximum function, an expedited review will be allowed. An expedited external review may be requested by calling the toll-free number on your ID card or by sending a written request to the address set out in the decision letter.

We are responsible for selecting an IRO from the list of IROs that are certified by the State of Indiana Department of Insurance. A different IRO must be selected for each external review and we will not repeat a selection until all IROs have been used.

Reconsideration during the External Review Process

If, at any time during the external review process, you submit information to us that was not previously submitted for review, we have the right to reconsider our decision. At such time additional information is received and we wish to reconsider our decision, we shall notify the IRO and the external review will cease.

We will have 15 days to review the additional information and reconsider our decision. In the case of an expedited review, we will make a decision within 72 hours. We will notify you of our decision.

If we determine to uphold our original decision, you may request that the IRO resume the external review.

If we choose not to reconsider the additional information submitted, we will forward the information to the IRO within 2 business days of receipt of the information.

External Review Decision

In the case of a non-expedited review, the IRO's decision is to be made within 15 business days after the request is filed. The IRO is to notify us and you of the decision within 72 hours after making the decision.

An expedited review must be completed within 72 hours after all information is submitted to the IRO. The IRO is to notify us and you of the decision within 24 hours after making the decision.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of

providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes,

including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.

- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

All Savers Insurance Company

Individual Medical Policy

Schedule of Benefits

[UnitedHealthcare Gold Choice 1250, Gold Choice 1250-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior

authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also	$1,250 per Covered Person, not to exceed $2,500 for all Covered Persons in a family.

Payment Term And Description	Amounts
be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes

Payment Term And Description	Amounts		
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health	90%	Yes	Yes, after the Per Occurrence Deductible of

Payment Term And Description	Amounts		
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			$250 per visit is satisfied.
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Private Duty Nursing visits provided in a home setting are limited to 82 visits per year to a maximum of 164 visits per lifetime.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			

Payment Term And Description		Amounts	
Lab Testing - Outpatient:	90%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	90%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90%	Yes	Yes
11. Mental Health Services			
•	*Inpatient* 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
•	*Inpatient* 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			

Payment Term And Description		Amounts	
	90%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	90%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures -*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $30 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Outpatient Diagnostic and Therapeutic. • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	***No***	No
18. Prosthetic Devices			
	90%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy.	90%	Yes	Yes

Payment Term And Description		Amounts	
• 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	90%	Yes	Yes
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90%	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	90%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
•	*Inpatient* 90%	Yes	Yes
•	*Outpatient* 100% after you pay a Copayment of $10 per visit	Yes	No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	90%	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Coverage for Dental			

Payment Term And Description		Amounts	
	90%	Yes	Yes
29. Autism Spectrum Disorders			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
31. Ostomy Supplies			
	90%	Yes	Yes
32. TMJ			
	90%	Yes	Yes
33. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
34. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible

Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services - (Subject to payment of the Annual Deductible.)	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%
Space Maintainers (Spacers) Benefit includes all adjustments	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy)	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services - (Subject to payment of the Annual Deductible.) Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants - (Subject to payment of the Annual Deductible.)	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice Individual Medical Policy

7440 Woodland Drive

Indianapolis, Indiana 46278-1719

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if: (A) we do not receive premiums when due, as described in the Policy; (B) a Covered Person has committed an act of fraud or made an intentional misrepresentation in connection with the Policy; (C) we discontinue offering and refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live; or (D) we discontinue offering and refuse to renew all individal policies/certificates in the individual market in the state where you reside. Please refer to Events Ending Your Coverage for further information.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

30-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 30 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, if any, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

- The study or investigation is conducted 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 clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits will also be provided for re-education or refresher training.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipmen*t. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug* subsection.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

5. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

11. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorder that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.

- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

13. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

14. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

15. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

16. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

17. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on

how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

18. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

19. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

20. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

21. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

23. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

24. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

25. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), chemotherapy (whether administered orally, intravenously, or by injection) or other intravenous infusion therapy and radiation oncology.

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

26. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

27. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

28. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

29. Autism Spectrum Disorder Medical Services

Benefits are provided on the same basis as any other Sickness for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by a treating Physician for the treatment of Autism Spectrum Disorder. Any exclusion within the Policy that is inconsistent with the treatment plan will not apply.

Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

30. Cancer Chemotherapy

Covered Health Services include chemotherapy for the treatment of cancer, whether administered orally, intravenously or by injection.

31. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by dentures or bridges.

32. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

33. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

34. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

35. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

36. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

37. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health

management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly associated with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA)*

Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).

- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.

- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
    - Extraction, restoration and replacement of teeth.
    - Medical or surgical treatments of dental conditions.
    - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
    - Blood pressure cuff/monitor.
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

- The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
- The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.
18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.
19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
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 may be made up to six times during a calendar

year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Neurodevelopmental Disorders - Autism Spectrum Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

7. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.

- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.

- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
    - Treatment for spider veins.
    - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
15. In vitro fertilization regardless of the reason for treatment.

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 residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Fetal reduction surgery.
6. Abortion, except for Therapeutic Abortion.

P. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Q. Substance-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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

R. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

S. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.

2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.

3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

4. Eye exercise or vision therapy.

5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.

2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.

3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - ♦ Medically Necessary.
    - ♦ Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - ♦ Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:
    - ▪ Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - ▪ Related to judicial or administrative proceedings or orders.
    - ▪ Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
    - ▪ Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion

does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Subject to a determination of the Indiana Health Insurance Exchange, a newborn child of the Policyholder or the Policyholder's spouse will be covered from the time of birth until the 31st day after birth. Coverage will terminate on the 31st day following birth, unless we have received notice of the child's birth and any additional premium required. Coverage of the newborn child shall include coverage of Sickness and Injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including intpatient and outpatient expenses arising from medical and dental treatment involved in the management of cleft lip and cleft palate.

Subject to a determination of the Indiana Health Insurance Exchange, a child placed for adoption with the Policyholder or the Policyholder's spouse will be covered from the date of Placement until the 31st day following Placement unless the Placement is disrupted prior to legal adoption and the child is removed from the insured's custody. Coverage will terminate on the 31st day following Placement, unless we have received notice of the intent to adopt the child and any additional premium required.

"Placement" when used in reference to an adoption, means the earlier of:

- The date of placement for the purpose of adoption.
- The date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Time Limit on Certain Defenses

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent mistatements, made in the application for coverage shall be used to void the Policy or deny a claim for loss incurred after the expiration of this two year period.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Assistance

A toll free telephone number is available for a Covered Individual to obtain information about filing Grievances.

- The individuals that answer the toll free telephone number can assist the caller or forward the call to the appropriate department if additional information is needed.
- Calls can be received at least 40 normal business hours per week and at other times the calls will be recorded by voicemail.
- If a call is left on voicemail, a qualified individual will respond to the call the next business day after the call is received.
- The calls will be answered by individuals who speak the English language. Non-English languages will be translated through a third party translation service.

Assistance is also available for Covered Individuals with literacy, physical, health, or other impediments.

Initial Utilization Review Determinations

Within 2 business days after receiving a request for a Utilization Review Determination that includes all information necessary to complete the Utilization Review Determination, we or a Utilization Review agent acting on our behalf, will notify the Covered Individual of the Utilization Review Determination by mail or another means of communication.

If the Utilization Review Determination does not certify an admission, a service, or a procedure, the notice will include:

- If the Utilization Review Determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination;
- The procedures to file a Grievance; and
- The toll free telephone number that the Covered Individual may call to request a review of the determination or obtain further information about the right to file a Grievance.

Internal Review of Grievances

Non-Urgent Care Review Request: A Covered Individual has 180 days following receipt of an initial notification of a determination to file a Grievance orally or in writing.

Urgent Care Review Request: Expedited reviews are available for Grievances regarding urgent care.

- **Acknowledgement:** An acknowledgement of the Grievance, given orally or in writing, must be provided by us within 5 business days after receipt of the Grievance. The notice must include:
- The name, address, and telephone number of an individual to contact regarding the Grievance; and
- The date the Grievance was filed.

Reviewer's Requirements:

- All Grievances regarding urgent care will be reviewed by a physician.
- A Grievance regarding appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a panel of one or more qualified individuals appointed by us.

- The panel must include one or more individuals who:
  - Have knowledge of the medical condition, procedure, or treatment at issue;
  - Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment or service;
  - Were not involved in the original determination; and
  - Do not have a direct business relationship with the Covered Individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.
- The Covered Individual will be given the opportunity to appear in person before the panel or if unable to appear in person, otherwise appropriately communicate with the panel. The Covered Individual will be notified not less than 72 hours prior to the meeting of the panel.
- The panel will meet during normal business hours and at a place convenient to a Covered Individual who wishes to appear before or otherwise communicate with the panel.

- All other Grievances that are based in whole or in part on a medical judgment will be reviewed by a health care professional who has appropriate expertise in the field of medicine involved in the medical issue, was not involved in the original determination, and is not the subordinate of the original reviewer.
- If the Grievance concerns a Rescission action, a panel of individuals who were not involved in the original determination and who are not the subordinates of the original reviewer will review the Grievance.
- All other Grievances will be reviewed by an impartial person who was not involved in making the original determination, is not the subordinate of the original reviewer, and has sufficient experience, knowledge, and training to appropriately resolve the Grievance.

General Information:

- Covered Individuals have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
- Covered Individuals have the right to review the claim file and to present evidence and testimony as part of the internal review process.
- Covered Individuals may request reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge.
- All comments, documents, records and other information submitted by the Covered Individual relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial benefit determination, will be considered in the internal Grievance review.
- The Covered Individual will receive from us, as soon as possible, any new or additional evidence considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new information.
- The Covered Individual will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

- A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.
- The internal appeal process must be exhausted before the Covered Individual may request an external review, unless:
  - The plan provides a waiver of this requirement;
  - The plan fails to follow the appeal process; or
  - The Covered Individual files an urgent care external appeal at the same time as an urgent care internal appeal.
- Resolution Timeframe:
- A Grievance regarding non-urgent care must be resolved as expeditiously as possible, reflecting the clinical urgency of the situation, but no later than:
  - 45 days after the Grievance regarding Post-service Claims is filed; or
  - 30 days after the Grievance regarding Pre-service Claims is filed.
- We will first orally notify the Covered Individual of the Grievance decision regarding urgent care within:
  - 48 hours after the Grievance regarding a Utilization Review Determination is filed and all the information necessary to complete the review is received, or 72 hours after the Grievance is received, whichever is earlier; or
  - 72 hours for all Grievances that are not regarding Utilization Review Determinations.
- The oral notification will be followed by a written notice as described in the Notification of Determination provision below.

Notification of Determination: We will notify a Covered Individual in writing of the resolution of the Grievance immediately for Grievances regarding Pre-service Claims or within 5 business days after completing an investigation of a Grievance regarding Post-service Claims. The notice must include:

- A statement of our understanding of the Covered Individual's Grievance;
- The decision reached by us;
- The contractual basis for the decision, including reference to specific plan provisions on which the determination is made;
- If applicable, the medical rationale for the resolution stated in sufficient detail for the Covered Individual to respond further to our position;
- Reference to the evidence or documentation used as the basis for the resolution, including a statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Individual's claim for benefits;
- The specific reason or reasons for the determination;
- A statement that the Covered Individual may have a right to bring a civil action under state or federal law;
- The specific rule, guideline, protocol, or other similar criterion, if used to make the determination, or that it will be provided free of charge upon request;
- The date of service;
- The health care provider's name;

- The claim amount;
- The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
- Our denial code with corresponding meaning;
- A description of any standard used, if any, in denying the claim;
- The department, address, and telephone number through which a Covered Individual may contact a qualified representative to obtain additional information about the decision or the next level of appeal available to them;
- If the Grievance is regarding appropriateness, medical necessity, experimental or investigational treatment or a Rescission:
    - Notice of the Covered Individual's right to external review by an independent review organization (IRO), including a description of the external review procedure; and
    - A copy of the Indiana Authorization Form which authorizes us to disclose protected health information for the external review; and
    - The plan must provide for the identification of medical experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the determination; and
- If applicable:
    - That assistance is available by contacting the specific state's consumer assistance department; and
    - A culturally linguistic statement based upon the Covered Individual's county or state of residence that provides for oral translation of the determination.

External Review

Non-Expedited Request:

- After exhausting the internal Grievance process, a Covered Individual has 120 days after notice of the second-level review resolution to request an external review in writing. A request for external review may only be made for a Grievance regarding:
    - A determination that a service or proposed service it not appropriate or Medically Necessary;
    - A determination that a service or proposed service is experimental or investigational; or
    - Our decision to Rescind an accident and sickness insurance policy.
- The Covered Individual is permitted to submit additional information regarding the proposed service throughout the external review process.
- The Covered Individual must sign an authorization form to release necessary medical information.

Expedited Request: An expedited request maybe made for Grievances related to a Sickness, disease, condition, Injury, or disability if the time frame for a standard review would seriously jeopardize the Covered Individual's:

- Life or health; or
- Ability to reach and maintain maximum function.

Procedure:

- When a request for external review is filed, we will:

- Select an IRO from a list of IROs that are certified by the Department of Insurance (DOI); and
- Rotate the choice of an IRO among all certified IROs before repeating a selection.

- We will cooperate with the IRO by promptly providing the IRO with any information requested by the IRO.
- If, at any time during an external review, the Covered Individual submits information to us that is relevant to our resolution and was not previously considered, we may reconsider the previous resolution.
  - The IRO will cease the external review process until the reconsideration is completed.
  - We will notify the Covered Individual of the decision within 15 business days after the information is submitted (72 hours for an expedited review).
  - If our decision is adverse to the Covered Individual, the Covered Individual may request that the IRO resume the external review.
- If we choose not to reconsider, we will forward the submitted information to the IRO within 2 business days after receipt.

Resolution Timeframe and Notification of Determination:

- The IRO will make a determination to uphold or reverse our determination within 15 business days (3 business days for expedited) after the request for external review is filed. The IRO will base their determination on information gathered from the Covered Individual or the Covered Individual's designee, us, and the treating health care provider, and any additional information that the IRO considers necessary and appropriate.
- The IRO will notify us and the Covered Individual of their determination within 72 hours (24 hours for expedited) of making the determination.

General Information:

- An external review decision is binding on us.
- We will pay for all costs of the external review by the IRO.

Definitions

As used in this section, the following terms have the meanings indicated.

Authorized Representative means:

- A person to whom a Covered Individual has given express written consent to represent the Covered Individual;
- A person authorized by law to provide substituted consent for a Covered Individual; or
- A family member of the Covered Individual or the Covered Individual's treating health care professional when the Covered Individual is unable to provide consent.

For purposes of these procedures, a reference to a Covered Individual may also refer to an Authorized Representative.

Covered Individual means an individual who is covered under an accident and sickness insurance policy. For purposes of these procedures, and where applicable, a Covered Individual may also include:

- An Authorized Representative of the Covered Individual; and
- A Provider Of Record acting on behalf of the Covered Individual.

Grievance means any dissatisfaction expressed by or on behalf of a Covered Individual regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is experimental or investigational;
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between:
  - A Covered Individual and us; or
  - A group policyholder and us; or
- Our decision to Rescind an accident and sickness insurance policy;

and for which the Covered Individual has a reasonable expectation that action will be taken to resolve or reconsider the matter than is the subject of dissatisfaction.

Notification Involving Urgent Care means a Grievance that meets any of the following conditions:

- The time periods for making non-urgent care review recommendations:
  - Could seriously jeopardize the life or health of the Covered Individual or the ability of the Covered Individual to regain maximum function; or
  - In the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
- Other than above, the decision as to whether a condition involves urgent care is to be determined by the attending provider, and we must defer to such determination of the attending provider.

Pre-service Claim means any claim for benefits for medical care or treatment that requires our approval in advance of the Covered Individual obtaining the medical care.

Provider Of Record means the physician or other licensed practitioner identified to a Utilization Review agent as having primary responsibility for the care, treatment, and services rendered to a Covered Individual.

Post-service Claim means any claim for benefits for medical care or treatment that is not a Pre-service Claim.

Rescind or **Rescission** means a cancellation or discontinuance of coverage by us that has a retroactive effect.

Utilization Review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a Covered Individual. The term does not include:

- Elective requests for clarification of coverage, eligibility, or benefits verification; or
- Medical claims review.

Utilization Review Determination means the rendering of a decision based on Utilization Review that denies or affirms either of the following:

- The necessity or appropriateness of the allocation of resources; or
- The provision or proposed provision of health care services to a Covered Individual.

The term does not include the identification of alternative, optional medical care that requires the approval of the Covered Individual and does not affect coverage or benefits if rejected by the Covered Individual.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive authority to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, as we determine, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

Individual Off-Exchange Qualified Health Plan Policy Amendment

All Savers Insurance Company

As described in this Amendment, the Qualified Health Plan Policy is modified to support coverage for Eligible Persons who wish to purchase the same Qualified Health Plan coverage off the individual exchange.

1. *Section 3: When Coverage Begins and Premiums* is replaced in its entirety with the following:

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete and submit an application for insurance and make the required Premium payment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

Who is eligible to enroll and who qualifies as a Dependent will be determined by us under the terms of this Policy.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules for coverage under this Policy and as determined based on information submitted in the application for coverage. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can apply for insurance for themselves and their Dependents, as determined by state or federal law.

Coverage begins on the date identified in this Policy if we receive the completed application and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by state or federal law.

Adding New Dependents

Policyholders may apply for insurance for Dependents only as described below.

The Policyholder must notify us of a new Dependent to be added to this Policy. Additional Premium may also be required, and it will be calculated from the date coverage is effective.

Dependent Eligibility

Your Dependents become eligible for insurance on the later of following:

- The date you became insured under this Policy.
- The first day of the first full calendar month after the date of becoming your Dependent.

Effective Date for Initial Dependents:

The effective date for your initial Dependents, if any, is shown on the face page of the Policy. Only Dependents included in the application for insurance will be covered on your effective date.

Adding a Newborn Child:

A Dependent child born to you or your spouse will be covered from the time of birth until the 31st day after birth, unless you or your spouse advises us not to add the newborn child.

Adding an Adopted Child:

A Dependent child legally placed for adoption with you or your spouse will be covered from the date of placement until the 31st day after placement, unless the placement is disrupted prior to legal adoption and the child is removed from your or your spouse's custody.

As used in this provision, "placement" means the earlier of the following:

- The date that you or your spouse assume physical custody of the child for the purpose of adoption.
- The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.

Additional Premium:

Additional Premium may be required to continue coverage beyond the 31st day following the birth or placement of the child. The required Premium will be calculated from the date of birth or date of placement for adoption. Coverage of the child will terminate on the 31st day following birth or placement,

unless we have received both written notice of the child's birth or your or your spouse's intent to adopt the child and the required premium within 90 days of the date of birth or date of placement.

Adding Other Dependents:

If you submit an application for insurance on a Dependent and you pay the required Premiums, then the effective date will be shown in the written notice to you that the Dependent is insured.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

When adding a Dependent, Premiums shall be pro-rated based upon the effective date of the Dependent's coverage.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify us of your new residence. Your Premium will be based on your new residence beginning on the date determined by us. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

2. *Section 4: When Coverage Ends* is replaced in its entirety with the following:

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date we terminate as a Qualified Health Plan Issuer.
  - The date this benefit plan is decertified as a *Qualified Health Plan*.
  - The date we specify that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.

- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date you request if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy.

3. The definition of Eligible Person in *Section 8: Defined Terms* is replaced with the following:

Eligible Person - a person who meets the eligibility requirements for coverage under this Policy and as determined based on information submitted in the application. An Eligible Person must live within the Service Area.

_____

(Name and Title)

All Savers Insurance Company

Form Numbers:
IEXPOL.I.15.IN, et.al.

Rate Pages for State of Indiana Form Filing

For Policies Effective January 1, 2015 and Later

All Savers Insurance Company

PREMIUM CALCULATIONS

Calculated Medical Premium

For each person:
Medical Premium (monthly) = RDC of

Base Rate
x Plan Factor
x Age Factor
x Tobacco Factor (if applicable)
x Area Factor

RDC = Round to 2 decimals

Sum the Medical Premium for all persons to be covered. This Subtotal is the Total Monthly Premium.
Note: Only the 3 oldest dependent children under the age of 21 will be included in the premium calculation.

Total Quarterly Premium = Total Monthly Premium * 3

Notes
There is an administrative fee for processing checks returned for non-sufficient funds.
This will only be imposed after the insured has received written notice of the fee.

All Savers Insurance Company

Monthly Base Rate	$384.03

Designation	Deductible	Coinsurance	AV Calculated	Metal/Cat	Plan Factor
Gold Compass 1250	$1,250	90%	79.4%	Gold	1.1370
Silver Compass 2000	$2,000	70%	69.5%	Silver	1.0280
Silver Compass 3500-1	$3,500	80%	70.4%	Silver	1.0380
Silver Compass 5000	$5,000	80%	69.9%	Silver	1.0390
Bronze Compass 5500	$5,500	70%	61.0%	Bronze	0.9400
Silver Compass HSA 2600	$2,600	100%	68.1%	Silver	1.0000
Bronze Compass HSA 4900	$4,900	100%	58.3%	Bronze	0.8520

All Savers Insurance Company

Age	Age Factor	Tobacco Factor
<=20	0.635	1.00
21	1.000	1.05
22	1.000	1.05
23	1.000	1.05
24	1.000	1.05
25	1.004	1.05
26	1.024	1.05
27	1.048	1.05
28	1.087	1.05
29	1.119	1.05
30	1.135	1.05
31	1.159	1.05
32	1.183	1.05
33	1.198	1.05
34	1.214	1.05
35	1.222	1.10
36	1.230	1.10
37	1.238	1.10
38	1.246	1.10
39	1.262	1.10
40	1.278	1.10
41	1.302	1.10
42	1.325	1.10
43	1.357	1.10
44	1.397	1.10
45	1.444	1.10
46	1.500	1.10
47	1.563	1.10
48	1.635	1.10
49	1.706	1.10
50	1.786	1.20
51	1.865	1.20
52	1.952	1.20
53	2.040	1.20
54	2.135	1.20
55	2.230	1.20
56	2.333	1.20
57	2.437	1.20
58	2.548	1.20
59	2.603	1.20
60	2.714	1.20
61	2.810	1.20
62	2.873	1.20
63	2.952	1.20
64+	3.000	1.20

All Savers Insurance Company

State	Rating Area	County	Area Factor
IN	Rating Area 1	Lake LaPorte Porter	0.827
IN	Rating Area 2	Elkhart Kosciusko Marshall St. Joseph Starke	0.704
IN	Rating Area 3	Adams DeKalb Huntington Lagrange Noble Steuben Wabash Wells Whitley	0.690
IN	Rating Area 4	Allen	0.690
IN	Rating Area 5	Benton Jasper Newton Warren White	0.710
IN	Rating Area 6	Cass Fulton Howard Miami Pulaski	0.724
IN	Rating Area 7	Carroll Clinton Fountain Montgomery Putnam Tippecanoe Tipton	0.723
IN	Rating Area 8	Blackford Delaware Grant Jay Randolph	0.745
IN	Rating Area 9	Clay Parke Sullivan Vermillion Vigo	0.786

All Savers Insurance Company

State	Rating Area	County	Area Factor
IN	Rating Area 10	Boone Hamilton Hendricks Marion Morgan Shelby	0.786
IN	Rating Area 11	Fayette Hancock Henry Madison Union Wayne	0.760
IN	Rating Area 12	Bartholomew Decatur Jackson Jennings Rush	0.689
IN	Rating Area 13	Brown Johnson Lawrence Monroe Owen	0.717
IN	Rating Area 14	Dearborn Franklin Ohio Ripley Switzerland	0.787
IN	Rating Area 15	Daviess Dubois Greene Knox Martin Orange Perry Pike Spencer	0.670
IN	Rating Area 16	Clark Crawford Floyd Harrison Jefferson Scott Washington	0.574
IN	Rating Area 17	Gibson Posey Vanderburgh Warrick	0.731

All Savers Insurance Company

Choice Individual Medical Policy

7440 Woodland Drive

Indianapolis, Indiana 46278-1719

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if we refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, or there is fraud or a material misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

10-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, if any, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

- The study or investigation is conducted 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 clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits will also be provided for re-education or refresher training.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipmen*t. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug* subsection.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

5. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.

- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

11. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorder that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.

- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

13. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

14. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

15. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

16. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits in accordance with guidelines established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care, including Benefits for an Inpatient Stay at a Hospital or free standing birthing facility 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.

The mother is not required to give birth in a Hospital, or to stay in the Hospital for the minimum timeframes. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occcurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital.

Post-Delivery Care

We will pay Benefits for post-delivery care services delivered in an office or medical facility or through a home care visit by a physician, registered nurse or an advanced practice nurse whose scope of practice includes postpartum care in the area of maternal and newborn care.

Post-delivery care includes:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

When the mother and her Physician decide to shorten the length of Inpatient Stay to less than the minimum number of hours required, we will provide Benefits for all post-delivery care provided within 72 hours after discharge. When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for the post-delivery care determined to be Medically Necessary by the Physician responsible for discharging the mother or newborn.

Newborn Well Baby Care

We will provide Benefits for newborn well baby care according to guidelines established by the American Academy of Pediatrics. Newborn charges will be paid separately from the mother's charges. Each newborn Dependent must meet any applicable Copayment, Annual Deductible and Coinsurance amounts under the Policy.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital. Inpatient benefits for newborn well baby care services cease when the mother is discharged from the Hospital or free standing birthing center.
- Physician charges for routine examination of the child before discharge from the Hospital or free standing birthing center.
- Physician charges for circumcision.

Newborn well baby care that meets the definition of a Preventive Care Service will be paid under the Preventive Care Services Benefit.

17. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on

how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

18. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Aids and supports for defective parts of the body, including but not limited to internal heart valve, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.

- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens imlantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lense following surgery. If the Injury is to one eye or if cataracts are removed form only one eye and the Covered Person selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Restoration prosthesis (composite facial prosthesis).
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

19. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

20. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

21. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

23. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

24. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

25. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), chemotherapy (whether administered orally, intravenously, or by injection) or other intravenous infusion therapy and radiation oncology.

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine. We will not require you to receive dialysis treatment at a network provider dialysis facility if the nearest network provider is further than 30 miles from your home. If the nearest network dialysis provider is more than 30 miles from your home, we will process Benefits to a Non-network provider nearer to your home at the Network provider benefit level.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

26. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

27. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

28. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

29. Autism Spectrum Disorder Medical Services

Benefits are provided for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by a treating Physician.

Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

30. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

31. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

32. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

33. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

34. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

35. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

36. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly associated with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.

16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.

17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

18. Foreign Services are not covered unless required as an Emergency.

19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.

- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

   Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

   - The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
   - The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

9. Any product dispensed for the purpose of appetite suppression or weight loss.

10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

12. Unit dose packaging or repackagers of Prescription Drug Products.

13. Medications used for cosmetic purposes.

14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.

15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

16. Prescription Drug Products when prescribed to treat infertility.

17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.

18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.

19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.

6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Neurodevelopmental Disorders - Autism Spectrum Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

7. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.

- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

10. Biofeedback.

11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

12. Surgical and non-surgical treatment of obesity.

13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*

15. In vitro fertilization regardless of the reason for treatment.

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 residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

4. The reversal of voluntary sterilization.

5. Fetal reduction surgery.

6. Abortion, except for Therapeutic Abortion.

P. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

Q. Substance-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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.

3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.

5. Gambling disorders.

6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

R. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

S. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation

for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:
   - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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.

- **You Accept Reimbursement for Premium**

  You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:

  - Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
  - Indian tribes, tribal organizations or urban Indian organizations
  - State and Federal Government programs.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Assistance

A toll free telephone number is available for a Covered Individual to obtain information about filing Grievances.

- The individuals that answer the toll free telephone number can assist the caller or forward the call to the appropriate department if additional information is needed.
- Calls can be received at least 40 normal business hours per week and at other times the calls will be recorded by voicemail.
- If a call is left on voicemail, a qualified individual will respond to the call the next business day after the call is received.
- The calls will be answered by individuals who speak the English language. Non-English languages will be translated through a third party translation service.

Assistance is also available for Covered Individuals with literacy, physical, health, or other impediments.

Initial Utilization Review Determinations

Within 2 business days after receiving a request for a Utilization Review Determination that includes all information necessary to complete the Utilization Review Determination, we or a Utilization Review agent acting on our behalf, will notify the Covered Individual of the Utilization Review Determination by mail or another means of communication.

If the Utilization Review Determination does not certify an admission, a service, or a procedure, the notice will include:

- If the Utilization Review Determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination;
- The procedures to file a Grievance; and
- The toll free telephone number that the Covered Individual may call to request a review of the determination or obtain further information about the right to file a Grievance.

Internal Review of Grievances

Non-Urgent Care Review Request: A Covered Individual has 180 days following receipt of an initial notification of a determination to file a Grievance orally or in writing.

Urgent Care Review Request: Expedited reviews are available for Grievances regarding urgent care.

- **Acknowledgement:** An acknowledgement of the Grievance, given orally or in writing, must be provided by us within 5 business days after receipt of the Grievance. The notice must include:
- The name, address, and telephone number of an individual to contact regarding the Grievance; and
- The date the Grievance was filed.

Reviewer's Requirements:

- All Grievances regarding urgent care will be reviewed by a physician.
- A Grievance regarding appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a panel of one or more qualified individuals appointed by us.

- The panel must include one or more individuals who:
  - Have knowledge of the medical condition, procedure, or treatment at issue;
  - Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment or service;
  - Were not involved in the original determination; and
  - Do not have a direct business relationship with the Covered Individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.
- The Covered Individual will be given the opportunity to appear in person before the panel or if unable to appear in person, otherwise appropriately communicate with the panel. The Covered Individual will be notified not less than 72 hours prior to the meeting of the panel.
- The panel will meet during normal business hours and at a place convenient to a Covered Individual who wishes to appear before or otherwise communicate with the panel.

- All other Grievances that are based in whole or in part on a medical judgment will be reviewed by a health care professional who has appropriate expertise in the field of medicine involved in the medical issue, was not involved in the original determination, and is not the subordinate of the original reviewer.
- If the Grievance concerns a Rescission action, a panel of individuals who were not involved in the original determination and who are not the subordinates of the original reviewer will review the Grievance.
- All other Grievances will be reviewed by an impartial person who was not involved in making the original determination, is not the subordinate of the original reviewer, and has sufficient experience, knowledge, and training to appropriately resolve the Grievance.

General Information:

- Covered Individuals have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
- Covered Individuals have the right to review the claim file and to present evidence and testimony as part of the internal review process.
- Covered Individuals may request reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge.
- All comments, documents, records and other information submitted by the Covered Individual relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial benefit determination, will be considered in the internal Grievance review.
- The Covered Individual will receive from us, as soon as possible, any new or additional evidence considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new information.
- The Covered Individual will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

- A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.
- The internal appeal process must be exhausted before the Covered Individual may request an external review, unless:
  - The plan provides a waiver of this requirement;
  - The plan fails to follow the appeal process; or
  - The Covered Individual files an urgent care external appeal at the same time as an urgent care internal appeal.
- Resolution Timeframe:
- A Grievance regarding non-urgent care must be resolved as expeditiously as possible, reflecting the clinical urgency of the situation, but no later than:
  - 45 days after the Grievance regarding Post-service Claims is filed; or
  - 30 days after the Grievance regarding Pre-service Claims is filed.
- We will first orally notify the Covered Individual of the Grievance decision regarding urgent care within:
  - 48 hours after the Grievance regarding a Utilization Review Determination is filed and all the information necessary to complete the review is received, or 72 hours after the Grievance is received, whichever is earlier; or
  - 72 hours for all Grievances that are not regarding Utilization Review Determinations.
- The oral notification will be followed by a written notice as described in the Notification of Determination provision below.

Notification of Determination: We will notify a Covered Individual in writing of the resolution of the Grievance immediately for Grievances regarding Pre-service Claims or within 5 business days after completing an investigation of a Grievance regarding Post-service Claims. The notice must include:

- A statement of our understanding of the Covered Individual's Grievance;
- The decision reached by us;
- The contractual basis for the decision, including reference to specific plan provisions on which the determination is made;
- If applicable, the medical rationale for the resolution stated in sufficient detail for the Covered Individual to respond further to our position;
- Reference to the evidence or documentation used as the basis for the resolution, including a statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Individual's claim for benefits;
- The specific reason or reasons for the determination;
- A statement that the Covered Individual may have a right to bring a civil action under state or federal law;
- The specific rule, guideline, protocol, or other similar criterion, if used to make the determination, or that it will be provided free of charge upon request;
- The date of service;
- The health care provider's name;

- The claim amount;
- The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
- Our denial code with corresponding meaning;
- A description of any standard used, if any, in denying the claim;
- The department, address, and telephone number through which a Covered Individual may contact a qualified representative to obtain additional information about the decision or the next level of appeal available to them;
- If the Grievance is regarding appropriateness, medical necessity, experimental or investigational treatment or a Rescission:
    - Notice of the Covered Individual's right to external review by an independent review organization (IRO), including a description of the external review procedure; and
    - A copy of the Indiana Authorization Form which authorizes us to disclose protected health information for the external review; and
    - The plan must provide for the identification of medical experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the determination; and
- If applicable:
    - That assistance is available by contacting the specific state's consumer assistance department; and
    - A culturally linguistic statement based upon the Covered Individual's county or state of residence that provides for oral translation of the determination.

External Review

Non-Expedited Request:

- After exhausting the internal Grievance process, a Covered Individual has 120 days after notice of the second-level review resolution to request an external review in writing. A request for external review may only be made for a Grievance regarding:
    - A determination that a service or proposed service it not appropriate or Medically Necessary;
    - A determination that a service or proposed service is experimental or investigational; or
    - Our decision to Rescind an accident and sickness insurance policy.
- The Covered Individual is permitted to submit additional information regarding the proposed service throughout the external review process.
- The Covered Individual must sign an authorization form to release necessary medical information.

Expedited Request: An expedited request maybe made for Grievances related to a Sickness, disease, condition, Injury, or disability if the time frame for a standard review would seriously jeopardize the Covered Individual's:

- Life or health; or
- Ability to reach and maintain maximum function.

Procedure:

- When a request for external review is filed, we will:

- Select an IRO from a list of IROs that are certified by the Department of Insurance (DOI); and
- Rotate the choice of an IRO among all certified IROs before repeating a selection.

- We will cooperate with the IRO by promptly providing the IRO with any information requested by the IRO.
- If, at any time during an external review, the Covered Individual submits information to us that is relevant to our resolution and was not previously considered, we may reconsider the previous resolution.
  - The IRO will cease the external review process until the reconsideration is completed.
  - We will notify the Covered Individual of the decision within 15 business days after the information is submitted (72 hours for an expedited review).
  - If our decision is adverse to the Covered Individual, the Covered Individual may request that the IRO resume the external review.
- If we choose not to reconsider, we will forward the submitted information to the IRO within 2 business days after receipt.

Resolution Timeframe and Notification of Determination:

- The IRO will make a determination to uphold or reverse our determination within 15 business days (3 business days for expedited) after the request for external review is filed. The IRO will base their determination on information gathered from the Covered Individual or the Covered Individual's designee, us, and the treating health care provider, and any additional information that the IRO considers necessary and appropriate.
- The IRO will notify us and the Covered Individual of their determination within 72 hours (24 hours for expedited) of making the determination.

General Information:

- An external review decision is binding on us.
- We will pay for all costs of the external review by the IRO.

Definitions

As used in this section, the following terms have the meanings indicated.

Authorized Representative means:

- A person to whom a Covered Individual has given express written consent to represent the Covered Individual;
- A person authorized by law to provide substituted consent for a Covered Individual; or
- A family member of the Covered Individual or the Covered Individual's treating health care professional when the Covered Individual is unable to provide consent.

For purposes of these procedures, a reference to a Covered Individual may also refer to an Authorized Representative.

Covered Individual means an individual who is covered under an accident and sickness insurance policy. For purposes of these procedures, and where applicable, a Covered Individual may also include:

- An Authorized Representative of the Covered Individual; and
- A Provider Of Record acting on behalf of the Covered Individual.

Grievance means any dissatisfaction expressed by or on behalf of a Covered Individual regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is experimental or investigational;
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between:
  - A Covered Individual and us; or
  - A group policyholder and us; or
- Our decision to Rescind an accident and sickness insurance policy;

and for which the Covered Individual has a reasonable expectation that action will be taken to resolve or reconsider the matter than is the subject of dissatisfaction.

Notification Involving Urgent Care means a Grievance that meets any of the following conditions:

- The time periods for making non-urgent care review recommendations:
  - Could seriously jeopardize the life or health of the Covered Individual or the ability of the Covered Individual to regain maximum function; or
  - In the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
- Other than above, the decision as to whether a condition involves urgent care is to be determined by the attending provider, and we must defer to such determination of the attending provider.

Pre-service Claim means any claim for benefits for medical care or treatment that requires our approval in advance of the Covered Individual obtaining the medical care.

Provider Of Record means the physician or other licensed practitioner identified to a Utilization Review agent as having primary responsibility for the care, treatment, and services rendered to a Covered Individual.

Post-service Claim means any claim for benefits for medical care or treatment that is not a Pre-service Claim.

Rescind or **Rescission** means a cancellation or discontinuance of coverage by us that has a retroactive effect.

Utilization Review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a Covered Individual. The term does not include:

- Elective requests for clarification of coverage, eligibility, or benefits verification; or
- Medical claims review.

Utilization Review Determination means the rendering of a decision based on Utilization Review that denies or affirms either of the following:

- The necessity or appropriateness of the allocation of resources; or
- The provision or proposed provision of health care services to a Covered Individual.

The term does not include the identification of alternative, optional medical care that requires the approval of the Covered Individual and does not affect coverage or benefits if rejected by the Covered Individual.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive authority to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, as we determine, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

Indiana
Part III - Federal Actuarial Memorandum
All Savers Insurance Company
NAIC Number: 0707-82406
FEIN: 35-1665915
HIOS Issuer ID: 36373

Purpose

Following is a rate filing prepared by All Savers Insurance Company. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services. The purpose of this memorandum is to provide information relevant to Part I - Unified Rate Review Template.

This filing establishes the rates intended to be used for individual On-Exchange health benefit plans in Indiana for 2015.

This memorandum is intended solely for the information of and use by the Department of Health & Human Services and the Indiana Department of Insurance. It will demonstrate compliance with state and federal laws and regulations and is not intended to be used for any other purpose.

General Information

Company Identifying Information

Company Legal Name:	All Savers Insurance Company
State:	Indiana
HIOS Issuer ID:	36373
Market:	Individual
Effective Date:	January 1, 2015

Company Contact Information

Primary Contact Name:	James M. Shallow, ASA, MAAA
Primary Contact Telephone Number:	(920) 661-1071
Primary Contact Email Address:	jshallow@unitedhealthone.com

Proposed Rate Increase

This is an initial filing. No rate increase is requested at this time.

Experience Period Premium and Claims

All Savers Insurance Company has no existing individual market business in Indiana. Therefore, no historical claims experience exists. Since the Unified Rate Review Template requires entry of data in this section, amounts of $1 were entered so the spreadsheet could be validated and submitted.

Benefit Categories

All Savers Insurance Company has no existing individual market business in Indiana. Therefore, no historical claims experience exists.

Projection Factors

All Savers Insurance Company has no existing individual market business in Indiana. Therefore, no historical claims experience exists, and no adjustment factors were applied.

Credibility Manual Rate Development

Source and Appropriateness of Data Used

These rates are intended to be used on a guarantee issue basis. As All Savers Insurance Company does not have relevant historical experience for individual medical guarantee issue products, we relied on the guarantee issue claims experience and rate development of affiliated small group carriers to develop the credibility manual rate.

The experience used in the development of these rates is net of the appropriate coordination of benefit recoveries. Therefore, the rates reflect the necessary equitable reduction in premiums or costs to beneficiaries of such other insurance or contract rights.

Data Adjustments

1. Estimated Morbidity Differential of the Population Insured

   A key assumption in our manual rate development was the estimated morbidity differential between the individual and small group markets. Our judgment was that historical morbidity differentials for very small size employer groups versus the small group overall average would be an appropriate indicator for this morbidity differential. The chart below shows the historical experience of affiliated small group carriers for the following group sizes: 1-employee, 1-3 employees, and 1-50 employees. While historical morbidity for 1-employee groups could indicate a morbidity load of greater than 100%, we realize that this reflects a level of anti-selection due to the fact that the primary alternative market for these members was the highly underwritten individual market. In the post-2014 guarantee issue environment for the individual market, although we do expect there will still be some anti-selection in the individual market relative to the small group market, we do not anticipate it being quite this high. Additionally, the new products will include more extensive care management.

   Therefore, considering the above along with the potential impact of Medicaid spend-down on the individual exchange market in Indiana, we have assumed morbidity for this product of 1.15 times that of a comparable small group product before removing small group adjustments made due to early renewals and small employer market dropout that are not applicable to these individual plans.

Nationwide Experience

Small Group Size	Earned Premium	Incurred Claims	Member Months	Premium PMPM	Claims PMPM	Claims vs 1-50 ees
1ee	45,744,151	58,576,101	87,361	$523.62	$670.51	2.221
1-3ees	410,313,807	379,506,863	855,464	$479.64	$443.63	1.470
1-50ees	6,028,225,051	4,519,101,029	14,970,587	$402.54	$301.87	1.000

Morbidity Load Assumption: 1.150

2. Trend / Emerging Experience

   The manual rates were developed from an affiliated carrier's small group projections for the 2014 calendar year. They were adjusted for trend factors and emerging claims experience.

3. Benefit Differential

   Adjustments were made to the affiliated small group carrier's experience to reflect the benefit variations between the small group portfolio and our individual product. Additional adjustments were made to reflect changes in the preferred drug list.

4. Network Adjustments

   The affiliated carrier's small group projections for the 2014 calendar year include EPO experience. The individual plans included in this filing are EPO plans as well, so no adjustments for network differential were necessary.

5. Demographic Adjustment

   We anticipate our individual exchange business to have a different age/gender composition compared to that of the affiliated small group carrier's business. Therefore, an adjustment was made to the manual rate development to account for the difference in demographic mix.

Credibility of Experience

All Savers Insurance Company has no existing individual market business in Indiana, so zero credibility is applied to the base period experience. We believe the affiliated small group experience used for developing the manual rates to be fully credible. A specific credibility formula was not used for this determination, but rather informed actuarial judgment. As ASOP 25, section 3.4 states: "Professional Judgment – The actuary should use professional judgment when selecting, developing, or using a credibility procedure. The use of credibility procedures is not always a precise mathematical process."

Paid-to-Allowed Ratio

A paid-to-allowed ratio was estimated for each plan by trending an affiliated carrier's small group claims experience to 2015 and accounting for the variation in cost-sharing parameters. These ratios were weighted by the projected membership per plan to calculate the average paid-to-allowed factor shown in Worksheet 1 of the Unified Rate Review Template.

Risk Adjustment and Reinsurance

Projected Risk Adjustments Net of Risk Adjustment User Fees

We are assuming zero net payments for risk adjustments. The HHS Notice of Benefit and Payment Parameters for 2015 specifies a risk adjustment user fee of $0.08 PMPM.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

Reinsurance recoveries are expected to be 7.9% of incurred claims. This amount was derived using nationwide experience from an affiliated carrier trended to 2015. The recoveries were then calculated using the 2015 reinsurance parameters, as published in the HHS Notice of Benefit and Payment Parameters for 2015. The HHS Notice of Benefit and Payment Parameters for 2015 specifies a reinsurance premium of $3.67 PMPM.

Non-Benefit Expenses and Profit

Administrative Expense Load

The 9.44% administrative expense load includes: commissions, credit card fees, quality improvements, and SG&A.

1. Commissions: We anticipate an average commission rate of approximately 2.50% of premium for 2015.
2. Quality Improvements: We assumed 0.90% of premium for quality improvements based on data from an affiliated carrier.
3. SG&A: Our general and administrative expense assumption is based on experience of our affiliated small group carriers, adjusted for inflation and expected 2015 expense level. For this product in the state of Indiana, this equates to approximately 6.04% of premium for 2015.

Profit & Risk Margin

Our projected underwriting gain over the 2015 rating period is approximately 2.3% of premium.

Premium	100.0%
Claims	-84.8%
Reinsurance Recoveries	6.7%
Risk Adjustment Payments	0.0%
Premium Tax	-1.3%
Reinsurance Fees	-0.8%
Risk Adjustment User Fee	-0.0%
Insurer Fees	-2.1%
Exchange Fees	-3.5%
PCORI Fees	-0.0%
Commissions	-2.5%
Quality Improvements	-0.9%
SG&A	-6.0%
Pre-Tax Income:	**4.6%**
Income Tax *	-2.4%
After-Tax Income:	**2.3%**

**Income Tax is calculated as 35% * (Pre-Tax Income + Insurer Fees).*

***Figures may not tally due to rounding of display in the exhibit.*

Taxes and Fees

The 9.34% attributed to taxes and fees includes: premium tax, insurer fees, exchange fees, PCORI fees, and federal income tax.

1. Premium Tax: The premium tax rate is 1.3%.
2. Insurer Fees: Each insurance carrier's assessment of insurer fees will be based on earned health insurance premium in the prior year, with certain exclusions. UnitedHealthcare (parent company of All Savers Insurance Company) estimates that 2.13% of its 2015 premium will be allocated for insurer fees.
3. Exchange Fees: Exchange fees in the state of Indiana are 3.50%.
4. PCORI Fees: This product will be effective for the 2015 plan year. The PCORI fee is $2 per member per year, or $0.17 PMPM. For this product in the state of Indiana, this equates to approximately 0.04% of premium.
5. Federal Income Tax: Income tax is projected to be 2.37% of premium and is calculated as 35% * (Pre-Tax Income + Insurer Fees), since insurer fees are not tax deductible.

Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2015 is 88.0%.

Claims	84.8%
Quality Improvements	0.9%
Reinsurance Recoveries	-6.7%
Risk Adjustment Payments	0.0%
Total MLR Claims	**79.0%**
Premium	100.0%
Premium Tax	-1.3%
Income Tax	-2.4%
Reinsurance Fee	-0.8%
Insurer Fees	-2.1%
Exchange Fees	-3.5%
PCORI Fee	-0.0%
Risk Adjustment User Fees	-0.0%
Total MLR Premium	**89.8%**
MLR:	**88.0%**

**Income Tax is calculated as 35% * (Pre-Tax Income + Insurer Fees).*

***Figures may not tally due to rounding of display in the exhibit.*

Single Risk Pool

The single risk pool reflects all covered lives for every individual non-grandfathered product and plan combination for All Savers Insurance Company in the state of Indiana. It is established in accordance with the requirements of 45 CFR part 156, 156.80(d).

Index Rate

The index rate represents 99.85% of the projected allowed claims PMPM for this block of business. Benefits in excess of essential health benefit requirements include outpatient post cochlear implant aural therapy, wigs for cancer patients and routine foot care for diabetics, which are anticipated to account for 0.15% of claims. The index rate for the projection period is $507.18.

Market Adjusted Index Rate

The market adjusted index rate includes market-wide adjustments for the federal reinsurance program, risk adjustment, and exchange user fees. The total expected impact for reinsurance recoveries and reinsurance fees is $25.89 PMPM. The total impact for risk adjustment payments and user fees are expected to be $0.08 PMPM. Please refer to the 'Risk Adjustment and Reinsurance' section for a brief description. Exchange user fees are approximately $15.44 PMPM. Please refer to the 'Non-Benefit Expenses and Profit' section for a brief description.

Since the Index Rate is at an allowed claim level and the reinsurance and risk adjustment values are at a paid level, the reinsurance and risk adjustment values are first divided by the Paid to Allowed Average Factor to compute the market adjustment. The market adjustment is then added to the Index Rate to yield the Market Adjusted Index Rate. The resulting market adjusted index rate is $493.10.

Index Rate	$507.18
Market Adjustment = ($15.44 + $0.08 - $25.89) / (0.737)	- $14.07
Market Adjusted Index Rate	$493.10

**Figures may not tally due to rounding of display in the exhibit.*

Plan Adjusted Index Rates

The plan adjusted index rates for each plan are listed below. They were calculated by beginning with the market adjusted index rate and adjusting for all allowable plan modifiers. The index rates vary due to different actuarial values and cost sharing designs by plan. The weighted average, based on projected membership, is $441.22.

- Gold Compass 1250: $490.70
- Silver Compass HSA 2600: $431.57
- Silver Compass 2000: $443.66
- Silver Compass 3500-1: $447.97
- Silver Compass 5000: $448.40
- Bronze Compass HSA 4900: $367.70
- Bronze Compass 5500: $405.68

The calculation for the *Gold Compass 1250 plan* is as follows:

Market Adjusted Index Rate	$493.10
Benefits in addition to EHB	+ $ 0.76
	$493.87
Paid to Allowed Average Factor	x 0.737
	$363.78
Distribution and Admin (Incl. Fees & Costs)	+ $77.43
	$441.22
Actuarial Value & Cost Share=(Pricing AV=1.137)/(Avg=1.022)	x 1.112
Plan Adjusted Index Rate	$490.70

**Figures may not tally due to rounding of display in the exhibit.*

Calibration

Calibration adjustments include age and geography, and they do not vary by plan.

Age Curve Calibration

The age calibration is 1.444, which is based on an average age assumption of 45 years. The HHS unisex age factors, included in Attachment A, were used.

Geographic Factor Calibration

The geographic factor calibration is 0.7402, which is based on our expected distribution of covered individuals. Attachment A includes the geographic factors for each of the counties in which All Savers Insurance Company intends to market this product. Geographic factors are based on experience from an affiliated carrier and include adjustments for differences in our provider networks.

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for each plan that is charged to an individual before applying the rating adjustments of age, area, and tobacco status. It is developed by calibrating the plan adjusted index rate for age and geography, and adjusting for any additional allowable rating factors specified by 45 CFR Part 147.102 (including tobacco).

Tobacco Adjustment

The tobacco adjustment is 1.007, which is based on the expected average tobacco factor (1.000 for non-tobacco users) for our expected distribution of covered individuals. See Attachment A for the tobacco factors by age.

Consumer Adjusted Premium Rates

The Consumer Adjusted Premium Rate is calculated as the Plan adjusted Index Rate divided by the product of the calibration factors and tobacco adjustment. Results for each plan are listed below. The weighted average, based on projected membership, is $409.93.

- Gold Compass 1250: $455.90
- Silver Compass HSA 2600: $400.97
- Silver Compass 2000: $412.20
- Silver Compass 3500-1: $416.21
- Silver Compass 5000: $416.61
- Bronze Compass HSA 4900: $341.63
- Bronze Compass 5500: $376.91

AV Metal Values

Our plan designs include post deductible copays in addition to per-occurrence copays paid in conjunction with coinsurance rates. Neither of these benefit designs are directly compatible with the AV calculator. For these unique plan designs, the alternate method described in 45 CFR 156.135(b)(2) was used for the AV calculations. Following is a description of how the inputs for these unique benefits were modified to fit the parameters of the AV calculator.

Per-Occurrence Copays Paid in Conjunction with Coinsurance Rates

In order to modify the inputs for this type of benefit design to fit the parameters of the AV calculator, the following formula was used to estimate the insurer's cost share.

$$\text{Effective Insurer Coinsurance Rate} = \left(1 - \frac{\text{Member Copay}}{\text{Average Unit Cost}}\right) * (1 - \text{Member Coinsurance Rate})$$

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. If the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. All enrollees within a continuance table were included in the calculation of the average unit cost for each benefit type.

The calculation of the average unit cost for the Outpatient Facility Fee is the one exception to the above methodology. Since the per-occurrence copay does not apply to all services included in the OP Facility Fee category within the AV calculator, the continuance tables did not provide the detail necessary for this calculation. Therefore, the average unit cost for the Outpatient Facility Fee was based on the historical experience of affiliated carriers in addition to our proprietary pricing model.

Post Deductible Copays

In order to modify the inputs for this type of benefit design to fit the parameters of the AV calculator, the following formula was used to estimate the insurer's cost share.

$$\text{Effective Insurer Coinsurance Rate} = \left(1 - \frac{\text{Member Copay}}{\text{Average Unit Cost}}\right)$$

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. If the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. Only those enrollees with claims greater than the plan deductible will pay the post deductible copay. Therefore, only those enrollees with total spending greater than the specified plan deductible were included in the calculation of the average unit cost for each benefit type.

Our prescription drug benefits are based on a drug categorization of Tier 1 to Tier 4, instead of the categories presented in the AV calculator (i.e. Generic, Preferred Brand, Non-Preferred Brand and Specialty). In addition, our Tier 3 and Tier 4 prescription drug benefits incorporate coinsurance rates along with minimum copay amounts. Based on historical experience of affiliated carriers and our expectations regarding the organization of brand and generic drugs into Tiers, the prescription drugs were re-categorized to match the parameters of the AV calculator, and the benefits were converted to equivalent member copays for each category. If the copay applies after the deductible, the equivalent member copay was then entered in the formula presented above in order to calculate the effective insurer coinsurance rate for each prescription category.

Benefits that Vary Based on Place of Service

For some types of services, our plan designs include different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility). To incorporate this differentiation in benefits, the Narrow Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

Plans Impacted by Alternative Methodology

The chart in Attachment B outlines which benefit adjustments were made to each plan included in this product.

Family Benefits

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

AV Pricing Values

The Silver Compass HSA 2600 plan is the fixed reference plan selected as the basis for the AV Pricing Values, with a pricing value of 1.000. The variation in rating factors for the other plans is based on the actuarial value and cost-sharing design differentiation relative to the Silver Compass HSA 2600 plan.

The medical plan price relativities were developed using the proprietary UnitedHealthcare pricing model. This model uses UnitedHealthcare nationwide experience data which is fully credible. Claim data is then projected to the pricing period based on national projections of utilization and unit costs. These projections are done at the service category level (inpatient, outpatient, etc.). Benefit design parameters such as deductibles, copays, and coinsurance rates are applied to the claim distributions of the matching service category. Cost-sharing is applied, and the values of each service category are summed to determine an overall benefit value. This overall benefit value is then compared to a base benefit design to calculate the plan relativity. All benefit plans are priced consistently with each other, with the rates differing only by the estimated value of the benefit differences.

In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations. The plan specific adjustments to the market wide index rate do not reflect differences in health status or risk selection.

Membership Projections

Since this is a new product with no historical experience, membership was estimated based on informed judgment.

Terminated Products

No products are being terminated at this time. All Savers Insurance Company has no existing individual market business.

Plan Type

A plan type of EPO has been selected for each plan, which describes the plans exactly.

Warning Alerts

There are no Warning Alerts in Worksheet 2 of the Unified Rate Review Template.

Reliance

Due to responsibility allocation, I relied on other UnitedHealthcare actuaries that have responsibility for small group rate development to provide the affiliated carrier experience data and rate development procedure for the small group rates.

Actuarial Certification

I, James M. Shallow, am an Associate Director of Actuarial Services for United Healthcare's Individual Line of Business, which includes All Savers Insurance Company's health insurance products marketed to individuals. I am a member of the American Academy of Actuaries, and I meet the Academy's qualification standards for rendering statements of actuarial opinion, with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment:

- The projected index rate is in compliance with all applicable state and federal statutes and regulations, and it was developed in compliance with the applicable Actuarial Standards of Practice.
- The benefits are reasonable in relation to the premiums charged and the population anticipated to be covered. In addition, premiums are not inadequate, excessive, or unfairly discriminatory.
- Only the allowable modifiers were used to generate plan level rates.
- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Unified Rate Review Template. The alternate method described in 45 CFR 156.135(b)(2) was used to fit the parameters of the AV calculator.
- The Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges, and for certification that the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers.



James M. Shallow, ASA, MAAA
Associate Director, Actuarial Services

5.9.14
Date

Attachment A:

Age	Age Factor	Tobacco Factor
<=20	0.635	1.00
21	1.000	1.05
22	1.000	1.05
23	1.000	1.05
24	1.000	1.05
25	1.004	1.05
26	1.024	1.05
27	1.048	1.05
28	1.087	1.05
29	1.119	1.05
30	1.135	1.05
31	1.159	1.05
32	1.183	1.05
33	1.198	1.05
34	1.214	1.05
35	1.222	1.10
36	1.230	1.10
37	1.238	1.10
38	1.246	1.10
39	1.262	1.10
40	1.278	1.10
41	1.302	1.10
42	1.325	1.10
43	1.357	1.10
44	1.397	1.10
45	1.444	1.10
46	1.500	1.10
47	1.563	1.10
48	1.635	1.10
49	1.706	1.10
50	1.786	1.20
51	1.865	1.20
52	1.952	1.20
53	2.040	1.20
54	2.135	1.20
55	2.230	1.20
56	2.333	1.20
57	2.437	1.20
58	2.548	1.20
59	2.603	1.20
60	2.714	1.20
61	2.810	1.20
62	2.873	1.20
63	2.952	1.20
64+	3.000	1.20

Rating Area	County	Area Factor
Rating Area 1	Lake LaPorte Porter	0.827
Rating Area 2	Elkhart Kosciusko Marshall St. Joseph Starke	0.704
Rating Area 3	Adams DeKalb Huntington Lagrange Noble Steuben Wabash Wells Whitley	0.690
Rating Area 4	Allen	0.690
Rating Area 5	Benton Jasper Newton Warren White	0.710
Rating Area 6	Cass Fulton Howard Miami Pulaski	0.724
Rating Area 7	Carroll Clinton Fountain Montgomery Putnam Tippecanoe Tipton	0.723
Rating Area 8	Blackford Delaware Grant Jay Randolph	0.745
Rating Area 9	Clay Parke Sullivan Vermillion Vigo	0.786

Rating Area	County	Area Factor
Rating Area 10	Boone Hamilton Hendricks Marion Morgan Shelby	0.786
Rating Area 11	Fayette Hancock Henry Madison Union Wayne	0.760
Rating Area 12	Bartholomew Decatur Jackson Jennings Rush	0.689
Rating Area 13	Brown Johnson Lawrence Monroe Owen	0.717
Rating Area 14	Dearborn Franklin Ohio Ripley Switzerland	0.787
Rating Area 15	Daviess Dubois Greene Knox Martin Orange Perry Pike Spencer	0.670
Rating Area 16	Clark Crawford Floyd Harrison Jefferson Scott Washington	0.574
Rating Area 17	Gibson Posey Vanderburgh Warrick	0.731

Attachment B:

Plan Name	Per-Occurrence Copays Paid in Conjunction with Coinsurance Rates	Post Deductible Copays
UnitedHealthcare Gold Compass 1250	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Silver Compass HSA 2600	*Not Applicable*	- Generic Drugs - Preferred Brand Drugs - Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Silver Compass 2000	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Silver Compass 3500-1	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Silver Compass 5000	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Bronze Compass HSA 4900	*Not Applicable*	- Generic Drugs - Preferred Brand Drugs - Non-Preferred Brand Drugs - Specialty Drugs
UnitedHealthcare Bronze Compass 5500	- Emergency Room Services - Imaging - Outpatient Facility Fee	- Generic Drugs - Preferred Brand Drugs - Non-Preferred Brand Drugs - Specialty Drugs

All Savers Insurance Company

Form Numbers:
IEXPOL.I.15.IN, et.al.

Rate Pages for State of Indiana Form Filing

For Policies Effective January 1, 2015 and Later

All Savers Insurance Company

PREMIUM CALCULATIONS

Calculated Medical Premium

For each person:
Medical Premium (monthly) = RDC of

Base Rate
x Plan Factor
x Age Factor
x Tobacco Factor (if applicable)
x Area Factor

RDC = Round to 2 decimals

Sum the Medical Premium for all persons to be covered. This Subtotal is the Total Monthly Premium.
Note: Only the 3 oldest dependent children under the age of 21 will be included in the premium calculation.

Total Quarterly Premium = Total Monthly Premium * 3

Notes
There is an administrative fee for processing checks returned for non-sufficient funds.
This will only be imposed after the insured has received written notice of the fee.

All Savers Insurance Company

Monthly Base Rate	$400.97

Designation	Deductible	Coinsurance	AV Calculated	Metal/Cat	Plan Factor
Gold Compass 1250	$1,250	90%	79.4%	Gold	1.1370
Silver Compass 2000	$2,000	70%	69.5%	Silver	1.0280
Silver Compass 3500-1	$3,500	80%	70.4%	Silver	1.0380
Silver Compass 5000	$5,000	80%	69.9%	Silver	1.0390
Bronze Compass 5500	$5,500	70%	61.0%	Bronze	0.9400
Silver Compass HSA 2600	$2,600	100%	68.1%	Silver	1.0000
Bronze Compass HSA 4900	$4,900	100%	58.3%	Bronze	0.8520

All Savers Insurance Company

Age	Age Factor	Tobacco Factor
<=20	0.635	1.00
21	1.000	1.05
22	1.000	1.05
23	1.000	1.05
24	1.000	1.05
25	1.004	1.05
26	1.024	1.05
27	1.048	1.05
28	1.087	1.05
29	1.119	1.05
30	1.135	1.05
31	1.159	1.05
32	1.183	1.05
33	1.198	1.05
34	1.214	1.05
35	1.222	1.10
36	1.230	1.10
37	1.238	1.10
38	1.246	1.10
39	1.262	1.10
40	1.278	1.10
41	1.302	1.10
42	1.325	1.10
43	1.357	1.10
44	1.397	1.10
45	1.444	1.10
46	1.500	1.10
47	1.563	1.10
48	1.635	1.10
49	1.706	1.10
50	1.786	1.20
51	1.865	1.20
52	1.952	1.20
53	2.040	1.20
54	2.135	1.20
55	2.230	1.20
56	2.333	1.20
57	2.437	1.20
58	2.548	1.20
59	2.603	1.20
60	2.714	1.20
61	2.810	1.20
62	2.873	1.20
63	2.952	1.20
64+	3.000	1.20

All Savers Insurance Company

State	Rating Area	County	Area Factor
IN	Rating Area 1	Lake LaPorte Porter	0.827
IN	Rating Area 2	Elkhart Kosciusko Marshall St. Joseph Starke	0.704
IN	Rating Area 3	Adams DeKalb Huntington Lagrange Noble Steuben Wabash Wells Whitley	0.690
IN	Rating Area 4	Allen	0.690
IN	Rating Area 5	Benton Jasper Newton Warren White	0.710
IN	Rating Area 6	Cass Fulton Howard Miami Pulaski	0.724
IN	Rating Area 7	Carroll Clinton Fountain Montgomery Putnam Tippecanoe Tipton	0.723
IN	Rating Area 8	Blackford Delaware Grant Jay Randolph	0.745
IN	Rating Area 9	Clay Parke Sullivan Vermillion Vigo	0.786

All Savers Insurance Company

State	Rating Area	County	Area Factor
IN	Rating Area 10	Boone Hamilton Hendricks Marion Morgan Shelby	0.786
IN	Rating Area 11	Fayette Hancock Henry Madison Union Wayne	0.760
IN	Rating Area 12	Bartholomew Decatur Jackson Jennings Rush	0.689
IN	Rating Area 13	Brown Johnson Lawrence Monroe Owen	0.717
IN	Rating Area 14	Dearborn Franklin Ohio Ripley Switzerland	0.787
IN	Rating Area 15	Daviess Dubois Greene Knox Martin Orange Perry Pike Spencer	0.670
IN	Rating Area 16	Clark Crawford Floyd Harrison Jefferson Scott Washington	0.574
IN	Rating Area 17	Gibson Posey Vanderburgh Warrick	0.731

Individual Off-Exchange Qualified Health Plan Policy Amendment

All Savers Insurance Company

As described in this Amendment, the Qualified Health Plan Policy is modified to support coverage for Eligible Persons who wish to purchase the same Qualified Health Plan coverage off the individual exchange.

1. *Section 3: When Coverage Begins and Premiums* is replaced in its entirety with the following:

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete and submit an application for insurance and make the required Premium payment. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

Who is eligible to enroll and who qualifies as a Dependent will be determined by us under the terms of this Policy.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules for coverage under this Policy and as determined based on information submitted in the application for coverage. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can apply for insurance for themselves and their Dependents, as determined by state or federal law.

Coverage begins on the date identified in this Policy if we receive the completed application and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by state or federal law.

Adding New Dependents

Policyholders may apply for insurance for Dependents only as described below.

The Policyholder must notify us of a new Dependent to be added to this Policy. Additional Premium may also be required, and it will be calculated from the date coverage is effective.

Dependent Eligibility

Your Dependents become eligible for insurance on the later of following:

- The date you became insured under this Policy.
- The first day of the first full calendar month after the date of becoming your Dependent.

Effective Date for Initial Dependents:

The effective date for your initial Dependents, if any, is shown on the face page of the Policy. Only Dependents included in the application for insurance will be covered on your effective date.

Adding a Newborn Child:

A Dependent child born to you or your spouse will be covered from the time of birth until the 31st day after birth, unless you or your spouse advises us not to add the newborn child.

Adding an Adopted Child:

A Dependent child legally placed for adoption with you or your spouse will be covered from the date of placement until the 31st day after placement, unless the placement is disrupted prior to legal adoption and the child is removed from your or your spouse's custody.

As used in this provision, "placement" means the earlier of the following:

- The date that you or your spouse assume physical custody of the child for the purpose of adoption.
- The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.

Additional Premium:

Additional Premium may be required to continue coverage beyond the 31st day following the birth or placement of the child. The required Premium will be calculated from the date of birth or date of placement for adoption. Coverage of the child will terminate on the 31st day following birth or placement,

unless we have received both written notice of the child's birth or your or your spouse's intent to adopt the child and the required premium within 90 days of the date of birth or date of placement.

Adding Other Dependents:

If you submit an application for insurance on a Dependent and you pay the required Premiums, then the effective date will be shown in the written notice to you that the Dependent is insured.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify us of your new residence. Your Premium will be based on your new residence beginning on the date determined by us. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

2. *Section 4: When Coverage Ends* is replaced in its entirety with the following:

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date we terminate as a Qualified Health Plan Issuer.
  - The date this benefit plan is decertified as a *Qualified Health Plan*.
  - The date we specify that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.

- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date you request if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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.

- **You Accept Reimbursement for Premium**

  You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:

  - Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
  - Indian tribes, tribal organizations or urban Indian organizations
  - State and Federal Government programs.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy.

3. The definition of Eligible Person in *Section 8: Defined Terms* is replaced with the following:

Eligible Person - a person who meets the eligibility requirements for coverage under this Policy and as determined based on information submitted in the application. An Eligible Person must live within the Service Area.

_____

(Name and Title)

All Savers Insurance Company

Choice Individual Medical Policy

7440 Woodland Drive

Indianapolis, Indiana 46278-1719

[1-877-855-6538]

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if we refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, or there is fraud or a material misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

10-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

[Officer's Signature]

President

This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Indiana. This Policy is governed by the laws of the State of Indiana.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this 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 Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, if any, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with 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 enrolled in the trial.

With respect to 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 is conducted 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 clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits will also be provided for re-education or refresher training.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipmen*t. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug* subsection.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* or *Additional Benefits Required Under Indiana Law - Orthotic Devices*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

5. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Health Services include, but are not limited to:

- Medical/social services.
- Diagnostic services.
- Nutritional counseling.
- Therapy services. However, Manipulative Treatment is not covered when rendered in the home. setting.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

  Covered Health Services for Private Duty Nursing do not include:

  - Private Duty Nursing services in an Inpatient setting.
  - Services 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.
  - Services once patient or caregiver is trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
  - Intermittent care.
- Home Infusion Therapy including injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parental Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

7. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

8. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

11. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.

- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorder that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Additional Benefits Required Under Indiana Law - Autism Spectrum Disorder Medical Services below.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

13. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

14. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

15. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

16. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 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.

17. 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.*
- 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.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast

pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by calling *Customer Care* at 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.
- Duration of a rental.
- Timing of an acquisition.

As required under Indiana law, Benefits under this section specifically include:

- Colorectal cancer examinations and laboratory tests for a Covered Person who is:
  - At least 50 years old; or
  - Under 50 and at a high risk for colorectal cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Prostate specific antigen screenings, including:
  - One annual test for men at least 50 years of age.
  - One annual test for men under the age of 50 who are at a high risk for prostate cancer as determined by the most recent published guidelines of the *American Cancer Society*.
- Screening mammography, including:
  - Annual mammograms for women under the age of 40 who are at risk for breast cancer. A woman at risk meets at least one of the following descriptions:
    - A woman with a personal history of breast cancer.
    - A woman with a personal history of breast disease that was proven benign by biopsy.
    - A woman whose mother, sister, or daughter has had breast cancer.
    - A woman who is at least 30 years of age and has not given birth.
  - One baseline mammogram before the age of 40 for women that are between the age of 35 and 40.
  - An annual mammogram for women age 40 and over.

18. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms and legs, including any orthotic custom fabricated brace or support designed as a component of the prosthetic device.
- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic

device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

19. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Note: This exclusion does not apply to newborns as coverage is provided for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Benefits for any post-mastectomy services will be provided even if the Covered Person was not enrolled with us at the time the mastectomy was received. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

20. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative 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.
- A Day Rehabilitation Program

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or as part of a Day Rehabilitation Program.

A "Day Rehabilitation Program" is for those patients who do not require inpatient care, but still require a rehabilitation program four to eight hours a day, 2 or more days a week at a facility that provides day rehabilitation services on an outpatient basis. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two different therapy services must be provided in order for the program to be considered a Covered Health Service.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

21. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

23. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.

- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

24. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

25. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

26. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy. Covered Health Services shall include charges incurred for donor searches for bone marrow/stem cell transplants for a covered transplant.

Transportation and lodging expenses associated with the transplant will be covered up to the maximum stated on the *Schedule of Benefits* when authorized by us

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

27. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Indiana Law

28. Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

We will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

29. Autism Spectrum Disorder Medical Services

Benefits are provided for services, including applied behavior analysis, that are provided in accordance with a written treatment plan prescribed by a treating Physician.

Psychiatric services for Autism Spectrum Disorders are described under Neurological Disorders - Autism Spectrum Disorder Services in this section.

For purposes of this benefit "autism spectrum disorder" means a neurological condition, including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

30. Dental Services - Accident Only

Dental services when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic x-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

31. Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

32. Orthotic Devices

Orthotic Devices that are:

- Determined by the treating Physician to be Medically Necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Benefits include costs incurred for:

- The initial purchase and fitting.
- Casting (when billed with Orthotic Device), molding, fittings and adjustments.
- Applicable tax, shipping, postage and handling charges.

Orthotic devices may be replaced once per year when Medically Necessary. Additional replacements will be allowed for Covered Persons under age 18 when necessitated due to rapid growth; or for any Covered Person when an appliance is damaged and cannot be repaired.

Covered Orthotic Devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.

- Slings.
- Wristlets.
- Built-up shoe (lifts).
- Custom made shoe inserts.
- Therapeutic shoes for diabetics

For purposes of this Benefit, "Orthotic Device" means a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

33. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

34. Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for the diagnosis and treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

35. Vision Correction Following Injury/Surgery

Eyeglasses (including frames) and contact lenses are Covered Health Services when they replace the function of the human lens for conditions caused by cataract surgery or Injury.

36. Wigs

Benefits for the first wig following cancer treatment, not to exceed one per calendar year.

Benefits under this section do not include wigs except as described above, regardless of the reason for hair loss.

Outpatient Prescription Drugs

This subsection details Benefits for Prescription Drug Products.

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which

the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and

pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* subsection. 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* subsection. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 8 Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Pediatric Dental Services

This Pediatric Dental Services subsection provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Pediatric Dental Services subsection terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

1. Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you obtain Covered Dental Services from a Network Dental Provider. Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Benefits are not available for Dental Services that are not provided by a Network Dental Provider.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in the *Pediatric Care Dental Services Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

2. Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in the *Pediatric Care Dental Services Schedule of Benefits* when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* below.

Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

3: Pediatric Dental Exclusions

Except as specifically provided under *2. Benefits for Pediatric Dental Services* or listed in the *Pediatric Care Dental Services Schedule of Benefits,* Benefits are not provided for the following:

1. Dental Services received from a non-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service under *2. Benefits for Pediatric Dental Services* or the *Pediatric Care Dental Services Schedule of Benefits.*
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly associated with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.

19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptiveorthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

This Pediatric Vision Services subsection provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Indiana Health Insurance Exchange.

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at [www.myuhcvision.com].

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Benefit Description

Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Pediatric Care Vision Services Schedule of Benefits*.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Claims for Low Vision Care Services

When obtaining Low Vision Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision services, you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.

- Covered Person's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services.*

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as specifically stated as a Covered Health Service in this Policy.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances, Orthotics and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Over-the-counter devices.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Ultrasonic nebulizers.

5. Devices and computers to assist in communication and speech.
6. Oral appliances for snoring.
7. Repairs to Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect.

8. Replacement of Orthotic Devices or prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

   Coverage for a drug or biologic that is prescribed for use in an anticancer chemotherapeutic regimen will not be excluded on the grounds that the drug has not been approved by the United States Food and Drug Administration (USFDA) for the particular indication for which prescribed if any of the following conditions are met:

   - The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
   - The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer-reviewed professional medical journal published in the United States or Great Britain.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

16. Prescription Drug Products when prescribed to treat infertility.

17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *PPACA* in order to comply with essential health benefits requirements.

18. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.

19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

23. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided for by this policy.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *PPACA* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

30. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

31. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

32. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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 Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Corrective shoes, unless an integral part of a leg brace.
7. Shoe inserts (unless custom made).
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

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 Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
10. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
11. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - Medically Necessary.
    - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Neurodevelopmental Disorders - Autism Spectrum Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

7. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition, except as specifically provided under this Policy.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.

- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive

if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
15. In vitro fertilization regardless of the reason for treatment.

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 residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Fetal reduction surgery.
6. Abortion, except for Therapeutic Abortion.

P. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Q. Substance-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 *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.

6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

R. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

S. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed, as we determine. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as specifically covered under Pediatric Vision Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction, except as specifically covered under Pediatric Vision Services.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

Benefits are not provided under *Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - ♦ Medically Necessary.
    - ♦ Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - ♦ Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:
    - ▪ Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - ▪ Related to judicial or administrative proceedings or orders.
    - ▪ Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*
    - ▪ Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Indiana Health Insurance Exchange. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior 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 is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Indiana Health Insurance Exchange determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Indiana Health Insurance Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Indiana Health Insurance Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Indiana Health Insurance Exchange.

Coverage begins on the date determined by the Indiana Health Insurance Exchange and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Indiana Health Insurance Exchange.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Indiana Health Insurance Exchange.

The Policyholder must notify the Indiana Health Insurance Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Indiana Health Insurance Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by the Indiana Health Insurance Exchange.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Refund of Premium Upon Death of Policyholder

Upon the death of the Policyholder, we will refund any unused premiums. Premium refunds will be prorated from the date following the death of the insured to the end of the period for which premium has been paid.

A person entitled to recive a refund must submit a request for the refund and provide proof of the Policyholder's death.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Indiana Health Insurance Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Indiana Health Insurance Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Indiana Health Insurance Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Indiana Health Insurance Exchange. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from the Indiana Health Insurance Exchange instructing us to end your coverage.

  Your coverage ends on the date determined by the Indiana Health Insurance Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

  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.

- **You Accept Reimbursement for Premium**

  You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:

  - Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
  - Indian tribes, tribal organizations or urban Indian organizations
  - State and Federal Government programs.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Indiana Health Insurance Exchange.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as we determine. 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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

Payment of Claims

Time for Payment of Claim

Benefits will be paid as soon as we receive all of the required information listed above.

Clean Claims

We will pay Benefits for a Clean Claim within 30 days of our receipt of an electronically submitted claim or within 45 days of our receipt of a paper claim. If we do not pay or deny the claim within the allotted timeframes, interest will accrue at the rate required by Indiana law, beginning with the date the applicable timeframe ended until the date the claim is paid.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint/grievance, or appeal, just follow these steps:

Assistance

A toll free telephone number is available for a Covered Individual to obtain information about filing Grievances.

- The individuals that answer the toll free telephone number can assist the caller or forward the call to the appropriate department if additional information is needed.
- Calls can be received at least 40 normal business hours per week and at other times the calls will be recorded by voicemail.
- If a call is left on voicemail, a qualified individual will respond to the call the next business day after the call is received.
- The calls will be answered by individuals who speak the English language. Non-English languages will be translated through a third party translation service.

Assistance is also available for Covered Individuals with literacy, physical, health, or other impediments.

Initial Utilization Review Determinations

Within 2 business days after receiving a request for a Utilization Review Determination that includes all information necessary to complete the Utilization Review Determination, we or a Utilization Review agent acting on our behalf, will notify the Covered Individual of the Utilization Review Determination by mail or another means of communication.

If the Utilization Review Determination does not certify an admission, a service, or a procedure, the notice will include:

- If the Utilization Review Determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination;
- The procedures to file a Grievance; and
- The toll free telephone number that the Covered Individual may call to request a review of the determination or obtain further information about the right to file a Grievance.

Internal Review of Grievances

Non-Urgent Care Review Request: A Covered Individual has 180 days following receipt of an initial notification of a determination to file a Grievance orally or in writing.

Urgent Care Review Request: Expedited reviews are available for Grievances regarding urgent care.

- **Acknowledgement:** An acknowledgement of the Grievance, given orally or in writing, must be provided by us within 5 business days after receipt of the Grievance. The notice must include:
- The name, address, and telephone number of an individual to contact regarding the Grievance; and
- The date the Grievance was filed.

Reviewer's Requirements:

- All Grievances regarding urgent care will be reviewed by a physician.
- A Grievance regarding appropriateness, medical necessity, or experimental or investigational treatment will be reviewed by a panel of one or more qualified individuals appointed by us.

- The panel must include one or more individuals who:
  - Have knowledge of the medical condition, procedure, or treatment at issue;
  - Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment or service;
  - Were not involved in the original determination; and
  - Do not have a direct business relationship with the Covered Individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.
- The Covered Individual will be given the opportunity to appear in person before the panel or if unable to appear in person, otherwise appropriately communicate with the panel. The Covered Individual will be notified not less than 72 hours prior to the meeting of the panel.
- The panel will meet during normal business hours and at a place convenient to a Covered Individual who wishes to appear before or otherwise communicate with the panel.

- All other Grievances that are based in whole or in part on a medical judgment will be reviewed by a health care professional who has appropriate expertise in the field of medicine involved in the medical issue, was not involved in the original determination, and is not the subordinate of the original reviewer.
- If the Grievance concerns a Rescission action, a panel of individuals who were not involved in the original determination and who are not the subordinates of the original reviewer will review the Grievance.
- All other Grievances will be reviewed by an impartial person who was not involved in making the original determination, is not the subordinate of the original reviewer, and has sufficient experience, knowledge, and training to appropriately resolve the Grievance.

General Information:

- Covered Individuals have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
- Covered Individuals have the right to review the claim file and to present evidence and testimony as part of the internal review process.
- Covered Individuals may request reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge.
- All comments, documents, records and other information submitted by the Covered Individual relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial benefit determination, will be considered in the internal Grievance review.
- The Covered Individual will receive from us, as soon as possible, any new or additional evidence considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new information.
- The Covered Individual will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the Covered Individual 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the Covered Individual will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

- A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.
- The internal appeal process must be exhausted before the Covered Individual may request an external review, unless:
  - The plan provides a waiver of this requirement;
  - The plan fails to follow the appeal process; or
  - The Covered Individual files an urgent care external appeal at the same time as an urgent care internal appeal.
- Resolution Timeframe:
- A Grievance regarding non-urgent care must be resolved as expeditiously as possible, reflecting the clinical urgency of the situation, but no later than:
  - 45 days after the Grievance regarding Post-service Claims is filed; or
  - 30 days after the Grievance regarding Pre-service Claims is filed.
- We will first orally notify the Covered Individual of the Grievance decision regarding urgent care within:
  - 48 hours after the Grievance regarding a Utilization Review Determination is filed and all the information necessary to complete the review is received, or 72 hours after the Grievance is received, whichever is earlier; or
  - 72 hours for all Grievances that are not regarding Utilization Review Determinations.
- The oral notification will be followed by a written notice as described in the Notification of Determination provision below.

Notification of Determination: We will notify a Covered Individual in writing of the resolution of the Grievance immediately for Grievances regarding Pre-service Claims or within 5 business days after completing an investigation of a Grievance regarding Post-service Claims. The notice must include:

- A statement of our understanding of the Covered Individual's Grievance;
- The decision reached by us;
- The contractual basis for the decision, including reference to specific plan provisions on which the determination is made;
- If applicable, the medical rationale for the resolution stated in sufficient detail for the Covered Individual to respond further to our position;
- Reference to the evidence or documentation used as the basis for the resolution, including a statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Individual's claim for benefits;
- The specific reason or reasons for the determination;
- A statement that the Covered Individual may have a right to bring a civil action under state or federal law;
- The specific rule, guideline, protocol, or other similar criterion, if used to make the determination, or that it will be provided free of charge upon request;
- The date of service;
- The health care provider's name;

- The claim amount;
- The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
- Our denial code with corresponding meaning;
- A description of any standard used, if any, in denying the claim;
- The department, address, and telephone number through which a Covered Individual may contact a qualified representative to obtain additional information about the decision or the next level of appeal available to them;
- If the Grievance is regarding appropriateness, medical necessity, experimental or investigational treatment or a Rescission:
    - Notice of the Covered Individual's right to external review by an independent review organization (IRO), including a description of the external review procedure; and
    - A copy of the Indiana Authorization Form which authorizes us to disclose protected health information for the external review; and
    - The plan must provide for the identification of medical experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the determination; and
- If applicable:
    - That assistance is available by contacting the specific state's consumer assistance department; and
    - A culturally linguistic statement based upon the Covered Individual's county or state of residence that provides for oral translation of the determination.

External Review

Non-Expedited Request:

- After exhausting the internal Grievance process, a Covered Individual has 120 days after notice of the second-level review resolution to request an external review in writing. A request for external review may only be made for a Grievance regarding:
    - A determination that a service or proposed service it not appropriate or Medically Necessary;
    - A determination that a service or proposed service is experimental or investigational; or
    - Our decision to Rescind an accident and sickness insurance policy.
- The Covered Individual is permitted to submit additional information regarding the proposed service throughout the external review process.
- The Covered Individual must sign an authorization form to release necessary medical information.

Expedited Request: An expedited request maybe made for Grievances related to a Sickness, disease, condition, Injury, or disability if the time frame for a standard review would seriously jeopardize the Covered Individual's:

- Life or health; or
- Ability to reach and maintain maximum function.

Procedure:

- When a request for external review is filed, we will:

- Select an IRO from a list of IROs that are certified by the Department of Insurance (DOI); and
- Rotate the choice of an IRO among all certified IROs before repeating a selection.

- We will cooperate with the IRO by promptly providing the IRO with any information requested by the IRO.
- If, at any time during an external review, the Covered Individual submits information to us that is relevant to our resolution and was not previously considered, we may reconsider the previous resolution.
  - The IRO will cease the external review process until the reconsideration is completed.
  - We will notify the Covered Individual of the decision within 15 business days after the information is submitted (72 hours for an expedited review).
  - If our decision is adverse to the Covered Individual, the Covered Individual may request that the IRO resume the external review.
- If we choose not to reconsider, we will forward the submitted information to the IRO within 2 business days after receipt.

Resolution Timeframe and Notification of Determination:

- The IRO will make a determination to uphold or reverse our determination within 15 business days (3 business days for expedited) after the request for external review is filed. The IRO will base their determination on information gathered from the Covered Individual or the Covered Individual's designee, us, and the treating health care provider, and any additional information that the IRO considers necessary and appropriate.
- The IRO will notify us and the Covered Individual of their determination within 72 hours (24 hours for expedited) of making the determination.

General Information:

- An external review decision is binding on us.
- We will pay for all costs of the external review by the IRO.

Definitions

As used in this section, the following terms have the meanings indicated.

Authorized Representative means:

- A person to whom a Covered Individual has given express written consent to represent the Covered Individual;
- A person authorized by law to provide substituted consent for a Covered Individual; or
- A family member of the Covered Individual or the Covered Individual's treating health care professional when the Covered Individual is unable to provide consent.

For purposes of these procedures, a reference to a Covered Individual may also refer to an Authorized Representative.

Covered Individual means an individual who is covered under an accident and sickness insurance policy. For purposes of these procedures, and where applicable, a Covered Individual may also include:

- An Authorized Representative of the Covered Individual; and
- A Provider Of Record acting on behalf of the Covered Individual.

Grievance means any dissatisfaction expressed by or on behalf of a Covered Individual regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is experimental or investigational;
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between:
  - A Covered Individual and us; or
  - A group policyholder and us; or
- Our decision to Rescind an accident and sickness insurance policy;

and for which the Covered Individual has a reasonable expectation that action will be taken to resolve or reconsider the matter than is the subject of dissatisfaction.

Notification Involving Urgent Care means a Grievance that meets any of the following conditions:

- The time periods for making non-urgent care review recommendations:
  - Could seriously jeopardize the life or health of the Covered Individual or the ability of the Covered Individual to regain maximum function; or
  - In the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
- Other than above, the decision as to whether a condition involves urgent care is to be determined by the attending provider, and we must defer to such determination of the attending provider.

Pre-service Claim means any claim for benefits for medical care or treatment that requires our approval in advance of the Covered Individual obtaining the medical care.

Provider Of Record means the physician or other licensed practitioner identified to a Utilization Review agent as having primary responsibility for the care, treatment, and services rendered to a Covered Individual.

Post-service Claim means any claim for benefits for medical care or treatment that is not a Pre-service Claim.

Rescind or **Rescission** means a cancellation or discontinuance of coverage by us that has a retroactive effect.

Utilization Review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a Covered Individual. The term does not include:

- Elective requests for clarification of coverage, eligibility, or benefits verification; or
- Medical claims review.

Utilization Review Determination means the rendering of a decision based on Utilization Review that denies or affirms either of the following:

- The necessity or appropriateness of the allocation of resources; or
- The provision or proposed provision of health care services to a Covered Individual.

The term does not include the identification of alternative, optional medical care that requires the approval of the Covered Individual and does not affect coverage or benefits if rejected by the Covered Individual.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. 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.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive authority to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, as we determine, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, 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 this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to this Policy are effective 31 days after we send written notice to the Policyholder.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

In the interest of saving time and money, you are encouraged to complete all the steps in the appeal process described in *Section 6: Questions, Complaints/Grievances and Appeals* before bringing any legal action against us for any other reason. If you want to bring 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 within three years of the event from which your complaint arises, if you do not complete the appeal process) or you lose any rights to bring such an action against us.

Change of Beneficiary

The right to change of beneficiary is reserved to the Policyholder and the consent of the beneficiary or beneficiaries shall not be requisite to surrender of assignment of this Policy or to any change of beneficiary or beneficiaries, or to any changes in this Policy.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Include when plan design applies an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Tier 3, and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Clean Claim - a claim with no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this ~~Rider~~ Policy.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Indiana Health Insurance Exchange. An Eligible Person must live within the Service Area.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Home Infusion Therapy - a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Inherited Metabolic Disease - a disease that is caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services 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, 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, 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) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be 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. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Necessary - Dental Services and supplies under the Pediatric Dental Services subsection which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Policy. This definition of Necessary relates only to Benefits under the Pediatric Dental Services subsection and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to [www.myuhc.com] or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Include when plan design applies an Out-of-Pocket Drug Maximum.

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, 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 this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and

modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Indiana Health Insurance Exchange.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Abortion - an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed under *Pediatric Vision Care Services.*

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Gold Choice 1250, Gold Choice 1250-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$1,250 per Covered Person, not to exceed $2,500 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	90%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Private Duty Nursing visits provided in a home setting are limited to 82 visits per year to a maximum of 164 visits per lifetime.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	90% at a free-standing lab	Yes	Yes
	70% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	90% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes

Payment Term And Description		Amounts	
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90% at a free-standing diagnostic center	Yes	Yes
	90% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			

Payment Term And Description		Amounts	
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	90%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $30 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	90%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation	90%	Yes	Yes

Payment Term And Description		Amounts	
therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	90%	Yes	Yes
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90% at a free-standing center	Yes	Yes
	90% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $250 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	90%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			

Payment Term And Description		Amounts	
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	 Yes Yes	 Yes No
24. Surgery - Outpatient			
	90% at an ambulatory surgical center	Yes	Yes
	90% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Payment Term And Description	Amounts		
Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.			
27. Urgent Care Center Services			
	90%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Coverage for Dental			
	90%	Yes	Yes
29. Autism Spectrum Disorders			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
31. Ostomy Supplies			
	90%	Yes	Yes
32. TMJ			
	90%	Yes	Yes
33. Vision Correction Following Injury/Surgery			

Payment Term And Description		Amounts	
	90%	Yes	Yes
34. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%
Space Maintainers (Spacers) Limited to 1 per 60 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%
Adjunctive Services	
General Services (including Emergency Treatment)	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
insertion. Limited to 1 per 6 months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy;	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Silver Choice HSA 2600, Silver Choice HSA 2600-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	

Payment Term And Description	Amounts
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$2,600 per Covered Person, not to exceed $5,200 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,450 per Covered Person, not to exceed $12,900 for all Covered Persons in a family.

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	100%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100% at a free-standing lab	Yes	Yes
	70% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA			

Payment Term And Description		Amounts	
and Nuclear Medicine - Outpatient			
	100% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described	100%	Yes	Yes

Payment Term And Description		Amounts	
below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy	100%	Yes	Yes

Payment Term And Description	Amounts		
procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	100%	Yes	Yes

Payment Term And Description		Amounts	
• 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100% at a free-standing center	Yes	Yes
	70% at an outpatient Hospital-based center	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100%	Yes	Yes

Payment Term And Description		Amounts	
	Outpatient 100%	Yes	Yes
24. Surgery - Outpatient			
	100% at an ambulatory surgical center	Yes	Yes
	70% at an outpatient Hospital-based surgical center	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Payment Term And Description		Amounts	
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes

Payment Term And Description		Amounts	
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers) Limited to 1 per 60 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services	
General Services (including Emergency Treatment)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

Silver Choice HSA 1900

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$1,900 per Covered Person, not to exceed $3,800 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**

Payment Term And Description		Amounts	
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**]	100%	Yes	Yes

Payment Term And Description	Amounts		
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100% at a free-standing lab	Yes	Yes
	70% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based	Yes	Yes

Payment Term And Description		Amounts	
	diagnostic center		
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			

Payment Term And Description		Amounts	
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery -*	100%	Yes	Yes

Payment Term And Description	Amounts		
Outpatient. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy.	100%	Yes	Yes

Payment Term And Description		Amounts	
• 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100% at a free-standing center	Yes	Yes
	70% at an outpatient Hospital-based center	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes

Payment Term And Description	Amounts		
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
24. Surgery - Outpatient			
	100% at an ambulatory surgical center	Yes	Yes
	70% at an outpatient Hospital-based surgical center	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Payment Term And Description	Amounts		
cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.			
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			

Payment Term And Description		Amounts	
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters*

(published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to 1 per 60 months. Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

Silver Choice HSA 550

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$550 per Covered Person, not to exceed $1,100 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**

Payment Term And Description		Amounts	
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	100%	Yes	Yes

Payment Term And Description	Amounts		
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100% at a free-standing lab	Yes	Yes
	80% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100% at a free-standing diagnostic center	Yes	Yes
	80% at an outpatient Hospital-based	Yes	Yes

Payment Term And Description		Amounts	
	diagnostic center		
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100% at a free-standing diagnostic center	Yes	Yes
	80% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			

Payment Term And Description		Amounts	
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	Yes	Yes
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery -*	100%	Yes	Yes

Payment Term And Description	Amounts		
Outpatient. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy.	100%	Yes	Yes

Payment Term And Description		Amounts	
• 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100% at a free-standing center	Yes	Yes
	80% at an outpatient Hospital-based center	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient	100%	Yes	Yes

Payment Term And Description		Amounts	
Day Rehabilitation Program.			
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	 Yes Yes	 Yes Yes
24. Surgery - Outpatient			
	100% at an ambulatory surgical center	Yes	Yes
	80% at an outpatient Hospital-based surgical center	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Payment Term And Description	Amounts		
Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.			
27. Urgent Care Center Services			
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes

Payment Term And Description		Amounts	
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for

specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your

Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to 1 per 60 months. Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

Silver Choice HSA 75

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$75 per Covered Person, not to exceed $150 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	Yes	Yes
	Air or Water Ambulance: 100%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	100%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100% at a free-standing lab	Yes	Yes
	80% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100% at a free-standing diagnostic center	Yes	Yes
	80% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA			

Payment Term And Description		Amounts	
and Nuclear Medicine - Outpatient			
	100% at a free-standing diagnostic center	Yes	Yes
	80% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this	100%	Yes	Yes

Payment Term And Description		Amounts	
Schedule of Benefits. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under	100%	Yes	Yes

Payment Term And Description		Amounts	
Rehabilitation Services - Outpatient Therapy.			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	100%	Yes	Yes

Payment Term And Description		Amounts	
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100% at a free-standing center	Yes	Yes
	80% at an outpatient Hospital-based center	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	100% at an ambulatory surgical center	Yes	Yes
	80% at an outpatient Hospital-based surgical center	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	Yes	Yes

Payment Term And Description	Amounts		
Additional Benefits Required By Indiana Law			
28. Anesthetic/Hospital Charges for Dental Care			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	100%	Yes	Yes
33. Ostomy Supplies			
	100%	Yes	Yes
34. TMJ			
	100%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is

usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.

- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers) Limited to 1 per 60 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services	
General Services (including Emergency Treatment)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Silver Choice 3500, Silver Choice 3500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	80%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80% at a free-standing lab	Yes	Yes
	60% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	80% at a free-standing diagnostic center	Yes	Yes
	60% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			

Payment Term And Description		Amounts	
	80% at a free-standing diagnostic center	Yes	Yes
	80% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-**	80%	Yes	Yes

Payment Term And Description		Amounts	
Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services -*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Outpatient Therapy.			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	80%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	80%	Yes	Yes

Payment Term And Description		Amounts	
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80% at a free-standing center	Yes	Yes
	80% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $400 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a	Yes	Yes

Payment Term And Description		Amounts	
	Copayment of $20 per visit	Yes	No
24. Surgery - Outpatient			
	80% at an ambulatory surgical center	Yes	Yes
	80% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	80%	Yes	Yes

Payment Term And Description		Amounts	
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
29. Autism Spectrum Disorders			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
32. Ostomy Supplies			
	80%	Yes	Yes
33. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			

Payment Term And Description		Amounts	
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.

- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%
Space Maintainers (Spacers) Limited to 1 per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%
Adjunctive Services	
General Services (including Emergency Treatment)	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Silver Choice 5000, Silver Choice 5000-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description		Amounts	
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80% *Air or Water Ambulance:* 80%	Yes Yes	Yes Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80% *Air or Water Ambulance:* 80%	Yes Yes	Yes Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	80%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80% at a free-standing lab	Yes	Yes
	60% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	80% at a free-standing diagnostic center	Yes	Yes
	60% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			

Payment Term And Description		Amounts	
	80% at a free-standing diagnostic center	Yes	Yes
	80% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-**	80%	Yes	Yes

Payment Term And Description		Amounts	
Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services -*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Outpatient Therapy.			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	80%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	80%	Yes	Yes

Payment Term And Description		Amounts	
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80% at a free-standing center	Yes	Yes
	80% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $400 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	80%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 80%	Yes	Yes

Payment Term And Description		Amounts	
	Outpatient 100% after you pay a Copayment of $20 per visit	Yes	No
24. Surgery - Outpatient			
	80% at an ambulatory surgical center	Yes	Yes
	80% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			

Payment Term And Description		Amounts	
	80%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthetic/Hospital Charges for Dental Care			
	80%	Yes	Yes
29. Autism Spectrum Disorders			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			

Payment Term And Description		Amounts	
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $1,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%
Space Maintainers (Spacers) Limited to 1 per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%
Adjunctive Services	
General Services (including Emergency Treatment)	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Silver Choice 2000, Silver Choice 2000-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$2,000 per Covered Person, not to exceed $4,000 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**

Payment Term And Description		Amounts	
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
agree to accept the Network level of reimbursement.)			
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	70%	Yes	Yes

Payment Term And Description	Amounts		
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70% at a free-standing lab	Yes	Yes
	50% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	70% at a free-standing diagnostic center	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes

Payment Term And Description	Amounts		
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	70% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 70%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $30 per visit	Yes	No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 70%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $30 per visit	Yes	No
13. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network	70%	Yes	Yes

Payment Term And Description		Amounts	
facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Therapeutic Treatments - Outpatient. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	70%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation	70%	Yes	Yes

Payment Term And Description		Amounts	
therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70% at a free-standing center	Yes	Yes
	70% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $200 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			

Payment Term And Description		Amounts	
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	 Yes Yes	 Yes No
24. Surgery - Outpatient			
	70% at an ambulatory surgical center	Yes	Yes
	70% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $200 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Payment Term And Description	Amounts		
transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.			
27. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
29. Autism Spectrum Disorders			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			

Payment Term And Description		Amounts	
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for

specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your

Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based	

Payment Term And Description	Amounts
on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%
Space Maintainers (Spacers)	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to 1 per 60 months. Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%
Adjunctive Services	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	70%
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures,	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

Silver Choice 2500

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$2,500 per Covered Person, not to exceed $5,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air or Water Ambulance: 80%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	80%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80% at a free-standing lab	Yes	Yes
	60% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	80% at a free-standing diagnostic center	Yes	Yes
	60% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80% at a free-standing		

Payment Term And Description		Amounts	
	diagnostic center	Yes	Yes
	80% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for**	80%	Yes	Yes

Payment Term And Description		Amounts	
any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	80%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment	80%	Yes	Yes

Payment Term And Description		Amounts	
• Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80% at a free-standing center	Yes	Yes
	80% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $400 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	80%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	80% at an ambulatory surgical center	Yes	Yes
	80% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	80%	Yes	Yes

Payment Term And Description	Amounts		
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	80%	Yes	Yes
29. Autism Spectrum Disorders			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is

usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.

- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%
Space Maintainers (Spacers) Limited to 1 per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%
Adjunctive Services	
General Services (including Emergency Treatment)	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

Silver Choice 3500-2

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description		Amounts	
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 80% *Air or Water Ambulance:* 80%	Yes Yes	Yes Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 80% *Air or Water Ambulance:* 80%	Yes Yes	Yes Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	80%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
7. Hospice Care			
	80%	Yes	Yes
8. Hospital - Inpatient Stay			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	80% at a free-standing lab	Yes	Yes
	60% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	80% at a free-standing diagnostic center 60% at an outpatient Hospital-based diagnostic center	Yes Yes	Yes Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80% at a free-standing diagnostic center	Yes	Yes
	80% at an outpatient Hospital-based	Yes	Yes

Payment Term And Description		Amounts	
	diagnostic center		
11. Mental Health Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $20 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to**	80%	Yes	Yes

Payment Term And Description		Amounts	
obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $20 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $40 per visit for services provided by any other Physician	Yes	No
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			

Payment Term And Description		Amounts	
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	80%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	80%	Yes	Yes

Payment Term And Description		Amounts	
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80% at a free-standing center	Yes	Yes
	80% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $400 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	80%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 80%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $20 per visit	Yes	No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	80% at an ambulatory surgical center	Yes	Yes
	80% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	80%	Yes	Yes

Payment Term And Description	Amounts		
Additional Benefits Required By Indiana Law			
28. Anesthetic/Hospital Charges for Dental Care			
	80%	Yes	Yes
29. Autism Spectrum Disorders			
	80%	Yes	Yes
30. Dental Services - Accident Only			
	80%	Yes	Yes
31. Inherited Metabolic Disease			
	80%	Yes	Yes
32. Orthotic Devices			
	80%	Yes	Yes
33. Ostomy Supplies			
	80%	Yes	Yes
34. TMJ			
	80%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	80%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	80%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is

usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.

- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $750 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug	

Payment Term And Description	Amounts
Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	80%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	80%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	80%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	80%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	80%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	80%
Space Maintainers (Spacers) Limited to 1 per 60 months.	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	80%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	80%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	80%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	80%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	80%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	80%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	80%
Oral Surgery, including Surgical Extraction	80%
Adjunctive Services	
General Services (including Emergency Treatment)	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	80%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	80%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	80%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	80%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	80%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	80%
Implant Supported Prosthetics Limited to 1 time per 60 months.	80%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	80%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	80%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	80%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	80%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	80%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	80%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	80%
Eyeglass Lenses	Once per year.	
• *Single Vision*		80%
• *Bifocal*		80%
• *Trifocal*		80%
• *Lenticular*		80%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		80%
• *Eyeglass frames with a retail cost of $130 - 160.*		80%
• *Eyeglass frames with a retail cost of $160 - 200.*		80%
• *Eyeglass frames with a retail cost of $200 - 250.*		80%
• *Eyeglass frames with a retail cost greater than $250.*		80%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	80%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	80%
• *Necessary Contact Lense*	Limited to a 12 month supply.	80%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

Silver Choice 1200

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$1,200 per Covered Person, not to exceed $2,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$5,200 per Covered Person, not to exceed $10,400 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	70%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70% at a free-standing lab	Yes	Yes
	50% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	70% at a free-standing diagnostic center	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			

Payment Term And Description		Amounts	
	70% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	 Yes Yes	 Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	 Yes Yes	 Yes No
13. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-**	70%	Yes	Yes

Payment Term And Description		Amounts	
Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services -*	100% after you pay a Copayment of $30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $60 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Outpatient Therapy.			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	70%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	70%	Yes	Yes

Payment Term And Description	Amounts		
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70% at a free-standing center	Yes	Yes
	70% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $400 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	70%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $30 per visit	Yes Yes	Yes No

Payment Term And Description	Amounts		
24. Surgery - Outpatient			
	70% at an ambulatory surgical center	Yes	Yes
	70% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	70%	Yes	Yes

Payment Term And Description		Amounts	
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
29. Autism Spectrum Disorders			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes
36. Wigs			

Payment Term And Description		Amounts	
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.

- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $500 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%
Space Maintainers (Spacers) Limited to 1 per 60 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%
Adjunctive Services	
General Services (including Emergency Treatment)	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Silver Choice 250, Silver Choice 250-1, Silver Choice 250-2]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	

Payment Term And Description	Amounts
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$250 per Covered Person, not to exceed $500 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	90%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	90% at a free-standing lab	Yes	Yes
	70% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	90% at a free-standing diagnostic center 70% at an outpatient Hospital-based diagnostic center	Yes Yes	Yes Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	90% at a free-standing diagnostic center	Yes	Yes

Payment Term And Description		Amounts	
	90% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to**	90%	Yes	Yes

Payment Term And Description		Amounts	
obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $30 per visit for services provided by any other Physician	Yes	No
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the			

Payment Term And Description	Amounts		
opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100 100%	No No No	No No No
18. Prosthetic Devices			
	90%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient	90%	Yes	Yes

Payment Term And Description		Amounts	
rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90% at a free-standing center	Yes	Yes
	90% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $250 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	90%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 90%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $10 per visit	Yes	No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	90% at an ambulatory surgical center	Yes	Yes
	90% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $250 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	90%	Yes	Yes

Payment Term And Description	Amounts		
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	90%	Yes	Yes
29. Autism Spectrum Disorders			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is

usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.

- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $250 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%
Space Maintainers (Spacers) Limited to 1 per 60 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%
Adjunctive Services	
General Services (including Emergency Treatment)	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
insertion. Limited to 1 per 6 months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy;	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Silver Choice 100, Silver Choice 100-1, Silver Choice 100-2]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	

Payment Term And Description	Amounts
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	$100 per Covered Person, not to exceed $200 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$550 per Covered Person, not to exceed $1,100 for all Covered Persons in a family.

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 90%	Yes	Yes
	Air or Water Ambulance: 90%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	90%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	90%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	90%	Yes	Yes
7. Hospice Care			
	90%	Yes	Yes
8. Hospital - Inpatient Stay			
	90%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	90% at a free-standing lab	Yes	Yes
	70% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	90% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			

Payment Term And Description		Amounts	
	90% at a free-standing diagnostic center	Yes	Yes
	90% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	90%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-**	90%	Yes	Yes

Payment Term And Description		Amounts	
Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services -*	100% after you pay a Copayment of $10 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $20 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
Outpatient Therapy.			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services **Lab, X-ray or other preventive tests** **Breast pumps**	100% 100% 100%	No No No	No No No
18. Prosthetic Devices			
	90%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	90%	Yes	Yes

Payment Term And Description		Amounts	
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	90% at a free-standing center	Yes	Yes
	90% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $200 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	90%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 90% *Outpatient* 100% after you pay a Copayment of $10 per visit	Yes Yes	Yes No

Payment Term And Description		Amounts	
24. Surgery - Outpatient			
	90% at an ambulatory surgical center	Yes	Yes
	90% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $200 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	90%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	90%	Yes	Yes

Payment Term And Description	Amounts		
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	90%	Yes	Yes
29. Autism Spectrum Disorders			
	90%	Yes	Yes
30. Dental Services - Accident Only			
	90%	Yes	Yes
31. Inherited Metabolic Disease			
	90%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
33. Ostomy Supplies			
	90%	Yes	Yes
34. TMJ			
	90%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	90%	Yes	Yes
36. Wigs			
Limited to 1 per year following cancer treatment.	90%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is

usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.

- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Drug Deductible or Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 3, and Tier 4 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible. **Coupons:** We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	***Tier 1*** No Annual Drug Deductible. ***Tier 2*** No Annual Drug Deductible. ***Tiers 3 and 4*** $100 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist	

Payment Term And Description	Amounts
Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	90%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	90%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	90%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	90%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	90%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	90%
Space Maintainers (Spacers) Limited to 1 per 60 months.	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	90%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	90%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	90%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	90%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	90%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	90%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	90%
Oral Surgery, including Surgical Extraction	90%
Adjunctive Services	
General Services (including Emergency Treatment)	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	90%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	90%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	90%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 12 months after the initial insertion. Limited to 1 time per 12 months.	90%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial	90%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
insertion. Limited to 1 per 6 months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	90%
Implant Supported Prosthetics Limited to 1 time per 60 months.	90%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	90%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	90%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	90%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	90%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	90%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy;	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	90%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	90%
Eyeglass Lenses	Once per year.	
• *Single Vision*		90%
• *Bifocal*		90%
• *Trifocal*		90%
• *Lenticular*		90%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		90%
• *Eyeglass frames with a retail cost of $130 - 160.*		90%
• *Eyeglass frames with a retail cost of $160 - 200.*		90%
• *Eyeglass frames with a retail cost of $200 - 250.*		90%
• *Eyeglass frames with a retail cost greater than $250.*		90%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	90%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	90%
• *Necessary Contact Lense*	Limited to a 12 month supply.	90%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Bronze Choice HSA 4900, Bronze Choice HSA 4900-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$4,900 per Covered Person, not to exceed $9,800 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$6,450 per Covered Person, not to exceed $12,900 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description		Amounts	
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100% *Air or Water Ambulance:* 100%	Yes Yes	Yes Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100% *Air or Water Ambulance:* 100%	Yes Yes	Yes Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	100%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	Yes	Yes
7. Hospice Care			
	100%	Yes	Yes
8. Hospital - Inpatient Stay			
	100%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100% at a free-standing lab	Yes	Yes
	70% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	100% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA			

Payment Term And Description		Amounts	
and Nuclear Medicine - Outpatient			
	100% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	Yes Yes	Yes Yes
13. Pharmaceutical Products - Outpatient			
	100%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this	100%	Yes	Yes

Payment Term And Description		Amounts	
Schedule of Benefits. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under	100%	Yes	Yes

Payment Term And Description		Amounts	
Rehabilitation Services - Outpatient Therapy.			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative	100%	Yes	Yes

Payment Term And Description		Amounts	
Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100% at a free-standing center	Yes	Yes
	70% at an outpatient Hospital-based center	Yes	Yes
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	100%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100%	Yes	Yes

Payment Term And Description		Amounts	
	Outpatient 100%	Yes	Yes
24. Surgery - Outpatient			
	100% at an ambulatory surgical center	Yes	Yes
	70% at an outpatient Hospital-based surgical center	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	100%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			

Payment Term And Description		Amounts	
	100%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Coverage for Dental			
	100%	Yes	Yes
29. Autism Spectrum Disorders			
	100%	Yes	Yes
30. Dental Services - Accident Only			
	100%	Yes	Yes
31. Inherited Metabolic Disease			
	100%	Yes	Yes
32. Orthotic Devices			
	90%	Yes	Yes
31. Ostomy Supplies			
	100%	Yes	Yes
32. TMJ			
	100%	Yes	Yes
33. Vision Correction Following Injury/Surgery			
	100%	Yes	Yes
34. Wigs			

Payment Term And Description		Amounts	
Limited to 1 per year following cancer treatment.	100%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.

- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers) Limited to 1 per 60 months.	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services	
General Services (including Emergency Treatment)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	100%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Bronze Choice 5500, Bronze Choice 5500-1]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some

Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered	$5,500 per Covered Person, not to exceed $11,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Benefit* the *Pediatric Vision Care Services Benefit* and the *Pediatric Dental Services Benefit.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that	$6,600 per Covered Person, not to exceed $13,200 for all Covered Persons in a family.

Payment Term And Description	Amounts
does not apply to the Out-of-Pocket Maximum.	

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			

Payment Term And Description	Amounts		
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 70%	Yes	Yes
	Air or Water Ambulance: 70%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

Payment Term And Description	Amounts		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care **Diabetes Self-Management Items**	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Benefit.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Benefit.*		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	70%	Yes	Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**	70%	Yes	Yes
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care			

Payment Term And Description		Amounts	
services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	70%	Yes	Yes
7. Hospice Care			
	70%	Yes	Yes
8. Hospital - Inpatient Stay			
	70%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	70% at a free-standing lab	Yes	Yes
	50% at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	70% at a free-standing diagnostic center	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			

Payment Term And Description		Amounts	
	70% at a free-standing diagnostic center	Yes	Yes
	70% at an outpatient Hospital-based diagnostic center	Yes	Yes
11. Mental Health Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $35 per visit	Yes Yes	Yes No
12. Neurodevelopmental Disorders - Autism Spectrum Disorder Services			
	Inpatient 70% *Outpatient* 100% after you pay a Copayment of $35 per visit	Yes Yes	Yes No
13. Pharmaceutical Products - Outpatient			
	70%	Yes	Yes
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described	70%	Yes	Yes

Payment Term And Description		Amounts	
below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**			
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy	100% after you pay a Copayment of $35 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of $75 per visit for services provided by any other Physician	Yes	No

Payment Term And Description	Amounts		
procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Breast pumps	100%	No	No
18. Prosthetic Devices			
	70%	Yes	Yes
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive	70%	Yes	Yes

Payment Term And Description		Amounts	
rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)			
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	70% at a free-standing center	Yes	Yes
	70% at an outpatient Hospital-based center	Yes	Yes, after the Per Occurence Deductible of $500 per date of service is satisfied
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program. •	70%	Yes	Yes
23. Substance-Related and Addictive Disorders Services			
	Inpatient 70%	Yes	Yes

Payment Term And Description		Amounts	
	Outpatient 100% after you pay a Copayment of $35 per visit	Yes	No
24. Surgery - Outpatient			
	70% at an ambulatory surgical center	Yes	Yes
	70% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $400 per visit is satisfied.
25. Therapeutic Treatments - Outpatient			
	70%	Yes	Yes
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Payment Term And Description		Amounts	
27. Urgent Care Center Services			
	70%	Yes	Yes
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	70%	Yes	Yes
29. Autism Spectrum Disorders			
	70%	Yes	Yes
30. Dental Services - Accident Only			
	70%	Yes	Yes
31. Inherited Metabolic Disease			
	70%	Yes	Yes
32. Orthotic Devices			
	70%	Yes	Yes
33. Ostomy Supplies			
	70%	Yes	Yes
34. TMJ			
	70%	Yes	Yes
35. Vision Correction Following Injury/Surgery			
	70%	Yes	Yes

Payment Term And Description		Amounts	
36. Wigs			
Limited to 1 per year following cancer treatment.	70%	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular

Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in this Policy before benefits for Outpatient Prescription Drugs are available to you. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge after you pay a Copayment of $150 per Prescription Order or Refill. However, you will not pay less than $150 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill. However, you will not pay less than $300 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	70%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	70%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	70%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	70%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	70%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	70%
Space Maintainers (Spacers) Limited to 1 per 60 months.	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	70%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	70%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	70%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	70%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	70%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	70%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	70%
Oral Surgery, including Surgical Extraction	70%
Adjunctive Services	
General Services (including Emergency Treatment)	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	70%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	70%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	70%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	70%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6	70%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	70%
Implant Supported Prosthetics Limited to 1 time per 60 months.	70%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	70%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	70%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	70%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	70%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	70%
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	70%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	70%
Eyeglass Lenses	Once per year.	
• *Single Vision*		70%
• *Bifocal*		70%
• *Trifocal*		70%
• *Lenticular*		70%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		70%
• *Eyeglass frames with a retail cost of $130 - 160.*		70%
• *Eyeglass frames with a retail cost of $160 - 200.*		70%
• *Eyeglass frames with a retail cost of $200 - 250.*		70%
• *Eyeglass frames with a retail cost greater than $250.*		70%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	70%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	70%
• *Necessary Contact Lense*	Limited to a 12 month supply.	70%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		75% of billed charges

All Savers Insurance Company

Choice

Individual Medical Policy

Schedule of Benefits

[Gold Choice $0, Silver Choice $0, Bronze Choice $0, Silver Choice HSA $0, Bronze Choice HSA $0]

Accessing Benefits

Choice offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Choice Network provider within the Network Area. You can confirm that your provider is a Choice Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

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 an All Savers 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, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* **table to determine how far in advance you must obtain prior authorization.**

- Ambulance - non-emergent air, water and ground.
- Clinical trials.
- Transplants.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	No Annual Deductible
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	$0 per Covered Person
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of:	

Payment Term And Description	Amounts
• The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	*Ground Ambulance:* 100% *Air or Water Ambulance:* 100%	No No	No No
Non-Emergency Ambulance Ground, air or water ambulance, as we determine appropriate.	*Ground Ambulance:* 100% *Air or Water Ambulance:* 100%	No No	No No
2. Clinical Trials			

Payment Term And Description	Amounts		
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
3. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and *Outpatient Prescription Drugs.* Benefits for diabetes supplies will be the same as those stated under *Outpatient Prescription Drugs*.		
4. Durable Medical Equipment			
You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	No	No
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of	100%	No	No

Payment Term And Description		Amounts	
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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.**			
6. Home Health Care			
Limited to 90 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	No	No
7. Hospice Care			
	100%	No	No
8. Hospital - Inpatient Stay			
	100%	No	No
9. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:			
	100% at a free-standing lab	No	No

Payment Term And Description		Amounts	
	100% at a Hospital-based lab	No	No
X-Ray and Other Diagnostic Testing - Outpatient:	100% at a free-standing diagnostic center	No	No
	100% at an outpatient Hospital-based diagnostic center	No	No
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100% at a free-standing diagnostic center	No	No
	100% at an outpatient Hospital-based diagnostic center	No	No
11. Mental Health Services			
	Inpatient 100%	No	No
	Outpatient 100%	No	No
12. Neurodevelopmental Disorders -			

Payment Term And Description		Amounts	
Autism Spectrum Disorder Services			
	Inpatient 100% *Outpatient* 100%	 No No	 No No
13. Pharmaceutical Products - Outpatient			
	100%	No	No
14. Physician Fees for Surgical and Medical Services			
Eligible Expenses for Covered Health Services provided by a non-Network facility based Physician in a Network facility will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.**	100%	No	No
15. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and*	100%	No	No

Payment Term And Description	Amounts		
Diagnostics - Outpatient. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy.*			
16. Pregnancy - Maternity Services			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
17. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No

Payment Term And Description		Amounts	
Breast pumps	100%	No	No
18. Prosthetic Devices			
	100%	No	No
19. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
20. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. • 12 visits of Manipulative Treatment • Day Rehabilitation Program limited to a maximum of 60 days (when combined with inpatient rehabilitation)	100%	No	No
21. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100% at a free-standing center	No	No

Payment Term And Description		Amounts	
	100% at an outpatient Hospital-based center	No	No
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 90 days per year in a Skilled Nursing Facility. • A combined maximum of 60 days per year in an Inpatient Rehabilitation Facility/Outpatient Day Rehabilitation Program.	100%	No	No
23. Substance-Related and Addictive Disorders Services			
	Inpatient 100% *Outpatient* 100%	No No	No No
24. Surgery - Outpatient			
	100% at an ambulatory surgical center	No	No
	100% at an outpatient Hospital-based surgical center	No	No

Payment Term And Description		Amounts	
25. Therapeutic Treatments - Outpatient			
	100%	No	No
26. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility. Donor searches for bone marrow/stem cell transplants for a covered transplant are limited to $30,000 per transplant. Lodging and transportation expenses associated with the transplant must be approved by us and are limited to $10,000 per transplant.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
27. Urgent Care Center Services			
	100%	No	No
Additional Benefits Required By Indiana Law			
28. Anesthesia/Hospital Charges for Dental Care			
	100%	No	No
29. Autism Spectrum Disorders			

Payment Term And Description		Amounts	
	100%	No	No
30. Dental Services - Accident Only			
	100%	No	No
31. Inherited Metabolic Disease			
	100%	No	No
32. Orthotic Devices			
	100%	No	No
33. Ostomy Supplies			
	100%	No	No
34. TMJ			
	100%	No	No
35. Vision Correction Following Injury/Surgery			
	100%	No	No
36. Wigs			
Limited to 1 per year following cancer treatment.	100%	No	No

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *Optuminsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters*

(published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient*.
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Choice Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Choice Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Choice Network provider, we will work with you and your Choice Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants[, ventricular assist device implantation] or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, 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 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 Physician.

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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products or Pharmaceutical Products, for which Benefits are described in your Policy, are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance 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 Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Your Copayment and/or Coinsurance 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 through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	No Copayment

Pediatric Dental Services Schedule of Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	100%
Periodic Oral Evaluation (Check up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100%
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100%
Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100%
Space Maintainers (Spacers)	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to 1 per 60 months. Benefit includes all adjustments within 6 months of installation.	
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery	
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	100%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	100%
Endodontics (Root Canal Therapy) Limited to 1 time per tooth per lifetime.	100%
Periodontal Surgery (Gum Surgery) Limited 1 quadrant or site per 36 months per surgical area.	100%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	100%
Periodontal Maintenance (Gum Maintenance) Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.	100%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	100%
Oral Surgery, including Surgical Extraction	100%
Adjunctive Services	

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.	100%
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	100%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	100%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	100%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	100%
Repairs or Adjustments to Full Dentures, Partial Dentures,	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	
Implants	
Implant Placement Limited to 1 time per 60 months.	100%
Implant Supported Prosthetics Limited to 1 time per 60 months.	100%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	100%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	100%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	100%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	100%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60	100%

Benefit Description and Limitations	Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
months.	
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	100%

Pediatric Vision Care Services Schedule of Benefits

Schedule of Benefits

Vision Care Service	Frequency of Service	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100%
Eyeglass Lenses	Once per year.	
• *Single Vision*		100%
• *Bifocal*		100%
• *Trifocal*		100%
• *Lenticular*		100%
Eyeglass Frames	Once per year.	
• *Eyeglass frames with a retail cost up to $130.*		100%
• *Eyeglass frames with a retail cost of $130 - 160.*		100%
• *Eyeglass frames with a retail cost of $160 - 200.*		100%
• *Eyeglass frames with a retail cost of $200 - 250.*		100%
• *Eyeglass frames with a retail cost greater than $250.*		100%

Vision Care Service	Frequency of Service	Benefit
Contact Lenses Fitting & Evaluation	Once per year	100%
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	100%
• *Necessary Contact Lense*	Limited to a 12 month supply.	100%
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		100% of billed charges
• Low vision therapy		100% of billed charges

INDIANA
Rate Filing Actuarial Memorandum
All Savers Insurance Company
NAIC Number 0707-82406
FEIN: 35-1665915

1. Benefit Structure

a. Scope and Purpose of Filing

Following is a rate filing prepared by All Savers Insurance Company ("the Company"). This filing has been prepared to provide the necessary information required by your insurance department.

The purpose of this filing is to file the initial rates, effective for calendar year 2015, for our Indiana individual On-Exchange product.

This memorandum is intended solely for the information of and use by the Indiana Department of Insurance. It will demonstrate compliance with state and federal laws and regulations and is not intended to be used for any other purpose.

b. Market

This product will be offered in the individual market.

c. Description of Benefits

These are ACA compliant, major medical expense policies sold to individuals and families. Plans cover a percentage of covered expenses in excess of a selected deductible, up to a defined coinsurance limit, and then 100% of covered expenses thereafter. On some plans, certain covered expenses are not subject to the base plan deductible and/or coinsurance but may be subject to a separate deductible and/or copay amounts. Deductibles are on a calendar year basis. There are additional limitations and exclusions for some specific services.

The plans provide coverage for the required essential health benefits. Benefits in excess of essential health benefit requirements include outpatient post cochlear implant aural therapy, wigs for cancer patients and routine foot care for diabetics, which are anticipated to account for 0.15% of claims. There are no state mandated benefits outside the essential health benefits.

2. Proposed Rates

Please see the attached rate book for a complete set of proposed rates. Policyholder premiums are impacted by the following items.

- Age
- Tobacco Use
- Geographic Area
- Plan
- Family Size

3. Projected Experience with Enrollment Projections

Projected experience for the 12 month calendar year rating period of 1/1/2015 – 12/31/2015 is illustrated below.

Calendar Year	Earned Premium	Incurred Claims[1]	Anticipated Loss Ratio	Federal MLR
2015	$26,128,552	$20,628,471	78.9%	88.0%

[1] *Incurred Claims include Risk Adjustment and Net Reinsurance Recoveries.*

The 88.0% projected loss ratio using the federally prescribed MLR methodology for calendar year 2015 is computed as follows.

Claims	84.8%
Quality Improvements	0.9%
Reinsurance Recoveries	-6.7%
Risk Adjustment Payments	0.0%
Total MLR Claims	**79.0%**
Premium	100.0%
Premium Tax	-1.3%
Income Tax	-2.4%
Reinsurance Fee	-0.8%
Insurer Fees	-2.1%
Exchange Fees	-3.5%
PCORI Fee	-0.0%
Risk Adjustment User Fees	-0.0%
Total MLR Premium	**89.8%**
MLR:	**88.0%**

**Income Tax is calculated as 35% * (Pre-Tax Income + Insurer Fees).*
***Figures may not tally due to rounding of display in the exhibit.*

4. Assumptions

Our starting monthly base rate, as indicated in the rate manual, is $400.97. These rates are intended to be used on a guarantee issue basis, and All Savers Insurance Company does not have relevant historical experience for individual medical guarantee issue products. Therefore, to develop our individual monthly base rate we started with guarantee issue small group data from affiliated carriers and made the appropriate adjustments to reach our final individual base rate. We adjusted the small group January 2014 rate for premium and benefit differentials between our individual product and the small group product using comparable plans. The monthly base rate level, as well as other pricing factors, will continue to be monitored and evaluated with changes proposed in the future as appropriate.

The below assumptions were used in pricing the Indiana On-Exchange product.

1. Estimated Morbidity Differential of the Population Insured

   A key assumption in our manual rate development was the estimated morbidity differential between the individual and small group markets. Our judgment was that historical morbidity differentials for very small size employer groups versus the small group overall average would be an appropriate indicator for this morbidity differential. The chart below shows the historical experience of affiliated small group carriers for the following group sizes: 1-employee, 1-3 employees, and 1-50 employees. While historical morbidity for 1-employee groups could indicate a morbidity load of greater than 100%, we realize that this reflects a level of anti-selection due to the fact that the primary alternative market for these members was the highly underwritten individual market. In the post-2014 guarantee issue environment for the individual market, although we do expect there will still be some anti-selection in the individual market relative to the small group market, we do not anticipate it being quite this high. Additionally, the new products will include more extensive care management.

   Therefore, considering the above along with the potential impact of Medicaid spend-down on the individual exchange market in Indiana, we have assumed morbidity for this product of 1.15 times that of a comparable small group product before removing small group adjustments made due to early renewals and small employer market dropout that are not applicable to these individual plans.

Nationwide Experience

Small Group Size	Earned Premium	Incurred Claims	Member Months	Premium PMPM	Claims PMPM	Claims vs 1-50 ees
1ee	45,744,151	58,576,101	87,361	$523.62	$670.51	2.221
1-3ees	410,313,807	379,506,863	855,464	$479.64	$443.63	1.470
1-50ees	6,028,225,051	4,519,101,029	14,970,587	$402.54	$301.87	1.000

Morbidity Load Assumption: 1.150

2. Trend / Emerging Experience
   The manual rates were developed from an affiliated carrier's small group projections for the 2014 calendar year. They were adjusted for trend factors and emerging claims experience.

3. Benefit Differential
   Adjustments were made to the affiliated small group carrier's experience to reflect the benefit variations between the small group portfolio and our individual product. Additional adjustments were made to reflect changes in the preferred drug list.

4. Network Adjustments
   The affiliated carrier's small group projections for the 2014 calendar year include EPO experience. The individual plans included in this filing are EPO plans as well, so no adjustments for network differential were necessary.

5. Demographic Adjustment
   We anticipate our individual exchange business to have a different age/gender composition compared to that of the affiliated small group carrier's business. Therefore, an adjustment was made to the manual rate development to account for the difference in demographic mix.

5. Premium Guarantee Provision

This product does not contain a rate guarantee as policyholders' rates will change each January, regardless of enrollment date.

6. Rating Factors

a. Age Factors

Premiums are adjusted by the HHS approved age factors that vary on an attained age basis.

Age	Age Factors	Age	Age Factors	Age	Age Factors
<=20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64+	3.000

b. Geographic Factors

Premiums are adjusted by Geographic Factors developed by the affiliate carrier.

Rating Area	Area Factor	Rating Area	Area Factor
Rating Area 1	0.827	Rating Area 9	0.786
Rating Area 2	0.704	Rating Area 10	0.786
Rating Area 3	0.690	Rating Area 11	0.760
Rating Area 4	0.690	Rating Area 12	0.689
Rating Area 5	0.710	Rating Area 13	0.717
Rating Area 6	0.724	Rating Area 14	0.787
Rating Area 7	0.723	Rating Area 15	0.670
Rating Area 8	0.745	Rating Area 16	0.574
		Rating Area 17	0.731

c. Tobacco

Premiums are adjusted by tobacco factors that vary by a ratio of 1:1.2 based on the age and tobacco status of the insured.

Age	Tobacco Factor	Age	Tobacco Factor	Age	Tobacco Factor
<=20	1.00	35	1.10	50	1.20
21	1.05	36	1.10	51	1.20
22	1.05	37	1.10	52	1.20
23	1.05	38	1.10	53	1.20
24	1.05	39	1.10	54	1.20
25	1.05	40	1.10	55	1.20
26	1.05	41	1.10	56	1.20
27	1.05	42	1.10	57	1.20
28	1.05	43	1.10	58	1.20
29	1.05	44	1.10	59	1.20
30	1.05	45	1.10	60	1.20
31	1.05	46	1.10	61	1.20
32	1.05	47	1.10	62	1.20
33	1.05	48	1.10	63	1.20
34	1.05	49	1.10	64+	1.20

d. Family Composition

The total premium for family coverage is calculated by summing the premiums for each individual family member. Only the three oldest covered children under age 21 are included for purposes of this calculation.

e. Benefit Plan Factors

The chart below details the AV Pricing Values for all plans included in this product.

Designation	Metal/Cat	Plan Factor
Gold Compass 1250	Gold	1.1370
Silver Compass 2000	Silver	1.0280
Silver Compass 3500-1	Silver	1.0380
Silver Compass 5000	Silver	1.0390
Bronze Compass 5500	Bronze	0.9400
Silver Compass HSA 2600	Silver	1.0000
Bronze Compass HSA 4900	Bronze	0.8520

f. ***Non-Benefit Expenses*** – (all percentages shown are percent of premium)

Our projected non-benefit expenses for the 2015 rating period are shown in the table below.

Premium	100.0%
Claims	-84.8%
Reinsurance Recoveries	6.7%
Risk Adjustment Payments	0.0%
Premium Tax	-1.3%
Reinsurance Fees	-0.8%
Risk Adjustment User Fee	-0.0%
Insurer Fees	-2.1%
Exchange Fees	-3.5%
PCORI Fees	-0.0%
Commissions	-2.5%
Quality Improvements	-0.9%
SG&A	-6.0%
Pre-Tax Income:	**4.6%**
Income Tax *	-2.4%
After-Tax Income:	**2.3%**

**Income Tax is calculated as 35% * (Pre-Tax Income + Insurer Fees).*
***Figures may not tally due to rounding of display in the exhibit.*

g. ***Impact of Contractual Arrangement***

i. Any impact of contractual agreements with health care providers and administrators will be reflected in our trend assumption.

7. Company Financial Position

Total Adjusted Capital exceeds 200% of the Authorized Control Level as defined by the NAIC.

8. Actuarial Certification/Rate Attestation

I, James M. Shallow, am an Associate Director of Actuarial Services for United Healthcare's Individual Line of Business, which includes All Savers Insurance Company's health insurance products marketed to individuals. I am a member of the American Academy of Actuaries, and I meet the Academy's qualification standards for rendering statements of actuarial opinion, with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment:

- This rate filing is in compliance with the applicable state and federal statutes and regulations.
- This rate filing is in compliance with the applicable actuarial standards of practice (ASOP).
- The same premium rate is being charged without regard to whether the plan is offered through a Marketplace or whether the plan is offered directly from the issuer or through an agent.

James M. Shallow 5.9.14

James M. Shallow, ASA, MAAA — Date
Associate Director, Actuarial Services