Filing at a Glance

Company:	UnitedHealthcare Insurance Company
Product Name:	2017 UHIC Large Group Forms
State:	District of Columbia
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	11/09/2016
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Author(s):	Esther Drew
Reviewer(s):	Andre Beard (primary)
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State: *District of Columbia* **Filing Company:** *UnitedHealthcare Insurance Company*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *2017 UHIC Large Group Forms*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
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Group Market Type: Employer
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Created By: Esther Drew
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Deemer Date:
Submitted By: Esther Drew

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

On behalf of UnitedHealthcare Insurance Company, I am submitting the enclosed Group Medical Product forms for your Department's review and approval. Our intent is to use these forms for large employer groups only.

Most of these forms replace the forms previously filed & approved under SERFF Tracking Number UHLC-130012240, however the Catalyst Rider was approved under SERFF Tracking Number UHLC-128314914. The Performance Rewards Amendment is NEW.

The Gender Dysphoria Rider previously approved on July 18, 2016 under SERFF Tracking Number UHLC-130641011 will continue to be used with these forms.

Company and Contact

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Filing Company Information

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CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number: 79413

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State: District of Columbia **Filing Company:** UnitedHealthcare Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: 2017 UHIC Large Group Forms
Project Name/Number: /

Form Schedule

Lead Form Number: COC17.CER.I.11.LG.DC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Certificate of Coverage	COC17.CER.I.11.LG.DC	CER	Initial		50.600	COC17-INS-2011-LG-DC.pdf
2		Choice Schedule of Benefits	SBN17.CHC.I.11.LG.DC	SCH	Initial		55.800	SBN17-Medical-INS-2011-Choice-LG-DC.pdf
3		Choice Plus Schedule of Benefits	SBN17.CHP.I.11.LG.DC	SCH	Initial		56.000	SBN17-Medical-INS-2011-Choice Plus-LG-DC.pdf
4		Options Schedule of Benefits	SBN17.OPT.I.11.LG.DC	SCH	Initial		54.500	SBN17-Medical-INS-2011-Options-LG-DC.pdf
5		Non-Diff Schedule of Benefits	SBN17.NDF.I.11.LG.DC	SCH	Initial		53.300	SBN17-Medical-INS-2011-NonDifferential-LG-DC.pdf
6		Outpatient Prescription Drug Rider (Network)	RDR.RX.NET.17.I.11.LG.DC	CERA	Initial		52.900	Rider17-INS-2011-Pharmacy Network-LG-DC.pdf
7		Outpatient Prescription Drug Rider (Network/Non-Network)	RDR.RX.PLS.17.I.11.LG.DC	CERA	Initial		50.900	Rider17-INS-2011-Pharmacy Network and Non-Network-LG-DC.pdf
8		Outpatient Prescription Drug Schedule of Benefits (Network)	RDR.RXSBN.NET.17.I.11.LG.DC	CERA	Initial		57.500	SBN17-Pharmacy-INS-2011-Pharmacy Network-LG-DC.pdf
9		Outpatient Prescription Drug Schedule of Benefits (Network/Non-Network)	RDR.RXSBN.PLS.17.I.11.LG.DC	CERA	Initial		59.200	SBN17-Pharmacy-INS-2011-Pharmacy Network and Non-Network-LG-DC.pdf

State: *District of Columbia*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *2017 UHIC Large Group Forms*
Project Name/Number: */*
Filing Company: *UnitedHealthcare Insurance Company*

Lead Form Number: COC17.CER.I.11.LG.DC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
10		Performance Rewards Amendment	POL.AMD.PR.I.11.DC	POLA	Initial		63.000	POL-AMD-PerformanceRewards.INS.DC.pdf
11		Catalyst Rider	CATL17.I.11.LG.DC	CERA	Initial		62.900	Rider17-INS-2011-Catalyst-LG-DC.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

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.

[[1]Use the "including" statement when any of the four Riders are part of the medical plan.]

[[2]Include the GID Rider when issued as part of the medical plan.]

[[3] Include the Outpatient Prescription Drug Rider except when issued to a group that has carved out RX benefits from their medical plan.]

[[4]Include pediatric dental and vision references when issued as part of the medical plan. Do not include if those products are being sold as stand-alone products.]

- Riders[[1], including [[2]the Gender Identify Disorder/Gender Dysphoria Treatment Rider] [,] [and] [[3]the *Outpatient Prescription Drug Rider*][,][and] [[4]the *Pediatric Dental Rider*] [and] [[4]the *Pediatric Vision Care Services Rider*]].
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

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

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

Other Information You Should Have

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

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

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the District of Columbia. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of District of Columbia are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

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

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

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

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

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

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

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

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

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

Be Aware this Benefit Plan Does Not Pay for All Health Services

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

[Product Variables:]

[1 Network/Non-Network plans, including Options PPO when network providers are responsible for prior authorization.]

[2 Network-only plans.]

[3 Options PPO when network providers are not responsible for prior authorization or Non-Differential PPO when prior authorization is required for any service.]

Some Covered Health Services require prior authorization. [1 In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services.] [2 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.] [3 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. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the final authority to do the following:

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

We may delegate this authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time 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 Benefit plan.

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, 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 going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

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

Notify You of Material Modifications

From time to time, your plan may change (i.e. Deductible/coinsurance, etc.) but before the change can go into effect, we will provide you with a 60 day notice of any material modification, including changes to preventive care benefits.

Certificate of Coverage Table of Contents

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

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

[Plan design variable.]

- The amount you must pay for these Covered Health Services (including any Annual Deductible, [Per Occurrence Deductible,] Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount 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."

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design. Include any other specific conditions for coverage described within the category.]

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

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

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.

- Acupuncturist.]

[2.] Ambulance Services

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

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

- From a non-Network Hospital to the closest Network Hospital.
- To the closest Network Hospital or facility that provides Covered Health Services that were not available at the original Hospital or facility.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.

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

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

[3.] 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.

[Include to support expanding clinical trial benefit to non-life-threatening cardiovascular disease.]

- [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.]

[Include to support expanding clinical trial benefit to non-life-threatening surgical musculoskeletal disorders.]

- [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.]

[Include to support expanding clinical trial benefit to other non-life-threatening diseases or disorders.]

- [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 service or item, 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. A category B device is a non-experimental/investigational device:
    - For which the underlying questions of safety and effectiveness for that device have been resolved, or;
    - Is known to be safe and effective because, for example, other manufacturers have obtained *FDA* approval or clearance for that device.
  - 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.

[Include to support expanding clinical trial benefit beyond PPACA requirements.]

[[1]Include when clinical trial benefit is expanded for cardiovascular disease. [2]Include when clinical trial benefit is expanded for musculoskeletal disorders. [3]Include when clinical trial benefit is expanded for other non-life-threatening diseases or disorders.]

[With respect to [[1]cardiovascular disease] [,] [and] [[2]musculoskeletal disorders of the spine, hip and knees] [,] [and] [[3]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)*, the *NCI Community Clinical Oncology Program*, the *NCI Clinical Trials Cooperative Group*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - The *AIDS Clinical Trials Group*.
  - The *Community Programs for Clinical Research in AIDS*.

- 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*) and registered with the *Department of Health and Human Services* that is associated with an institution that has a federal-wide assurance approved by the *Department of Health and Human Services* 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 the Policy.

[4.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

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

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

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

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

- Emergency 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.]

[6.] 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.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management for that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes. We have specific guidelines regarding benefits for Diabetes services. Contact us at the telephone number on the back of your ID card for information about these guidelines.

Diabetic Self-Management Items

[Durable Medical Equipment and Outpatient Prescription Drug coverage are variable only for groups that are not required to provide coverage for Essential Health Benefits.]

[Include paragraph below when group purchases the drug rider.]

[[1]Include only when group purchases benefits for durable medical equipment.]

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. [[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors[, including continuous glucose monitors], insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

[Include paragraph and bulleted list below when group does not purchase the drug rider.]

[[1]Include only when group does not purchase benefits for durable medical equipment.]

[[2]Include only when group purchases benefits for durable medical equipment.]

[Insulin pumps [[1]that are not fully implanted into the body] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- [[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors[, including continuous glucose monitors].
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

[Durable Medical Equipment is variable only for groups that are not required to provide coverage for Essential Health Benefits.]

[7.] [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).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.

- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

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

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

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

Benefits are available for repairs and replacement, except that:

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

[8.] 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).

In addition, reimbursement for the cost of one voluntary HIV screening test performed on the insured while receiving emergency medical services is permitted per year, regardless of necessity, per state mandate. HIV screening test shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by conducting a rapid-result test by means of the swabbing of a patient's gums, finger-prick blood test, or other suitable rapid-result test.

[Include if plan design includes retrospective review of emergency services.]

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

[9.] [Hearing Aids]

[Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs.

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] 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.

[11.] 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.

[12.] 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*.)

Coverage is provided for newborn infant hearing screenings and all necessary audio-logical examinations provided as recommended by the *National Joint Committee* on Infant Hearing. For the purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.

- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- [Be under age 44, if female.]
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.]

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 for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable, but not limited to, mammography testing performed as follows:
  - A baseline mammogram; and
  - Follow-up mammograms on an annual basis.
- Colorectal cancer screening: Coverage shall be provided for colorectal cancer screening in accordance with the latest screening guidelines issued by the *American Cancer Society* for the ages, family histories, and frequencies referenced in such guidelines.
- Prostate cancer screening: Coverage shall be provided for Prostate cancer screening in accordance with the latest screening guidelines issued by the *American Cancer Society* for the ages, family histories, and frequencies referenced in such guidelines.

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*.)

[Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.]

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

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

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

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

[Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.]

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*.)

[Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.]

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

[16.] Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

[17.] Neurobiological Disorders - Autism Spectrum Disorder Services

Behavioral services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavioral Analysis (ABA))* that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

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

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

[18.] [Obesity Surgery]

[Include the applicable criteria for coverage].

[Surgical treatment of obesity when provided by or under the direction of a Physician [when the Covered Person has a body mass index (BMI) greater than 40].

[Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- [The Covered Person must have a body mass index (BMI) of greater than 40.]
- [The Covered Person must have a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

[19.] [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.]

[20.] 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. [Benefits under this section do not include medications for the treatment of infertility.]

[Pharmaceutical Products are assigned to various tiers. The Prescription Drug List (PDL) Management Committee makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether prior authorization requirements should apply. Economic factors may include the Pharmaceutical Product's acquisition cost, including available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

Note: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

[If you require certain Pharmaceutical Products[, including specialty Pharmaceutical Products,] we may 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.

[[1]Applies to Network/Non-Network products.]

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, [[1]Network] 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.]

[Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Copayment and/or Coinsurance, you may receive Pharmaceutical Products 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 order or refill and/or the amount dispensed per month's supply.

You may determine whether a Pharmaceutical 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.]

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.

[21.] 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.

[22.] 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 freestanding, 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.

[[1]Include when Genetic Testing must be preceded by genetic counseling.]

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is [[1]determined to be Medically Necessary following genetic counseling when] 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*.

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. [2]Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.]

[Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [[2]Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.]]

[Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.]

[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*.]

[23.] 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.

In all cases of early discharge, we shall provide coverage for post-delivery care within the minimum time periods shown above in the Subscriber's home, or, in a provider's office, as determined by the Physician in consultation with the mother.

The at-home post-delivery care shall be provided by a registered professional nurse, Physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

(1). Parental education;

(2) Assistance and training in breast or bottle feeding; and

(3) Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

[24.] Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- 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* including those considered routine and necessary for newborn children from birth to 36 months of age.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* including annual cytology screening and any such screening deemed Medically Necessary by the Physician.

[[1]Include if information is available online.]

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 [[1]by going to [www.myuhc.com] or] 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.

Benefits for the services listed below are required under District of Columbia law:

- Preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy. Child health screenings and immunizations are covered for children from birth to age 21.
- With respect to women: annual cervical cytologic screening (pap smear) for women; and cervical cytologic screening for women upon certification by an attending physician that the test is medically necessary; a baseline mammogram for women; and an annual screening mammogram for women.
- Coverage must be provided for prostate cancer screening in accordance with the latest prostate cancer screening guidelines issued by the *American Cancer Society* for the ages, family histories and frequencies referenced in such guidelines.
- Coverage must be provided for colorectal cancer screening in compliance with the *American Cancer Society* colorectal cancer screening guidelines.

[Prosthetic Devices is variable only for groups that are not required to provide coverage for Essential Health Benefits.]

[25.] [Prosthetic Devices]

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

- Artificial arms, legs, feet and hands. Artificial face, eyes, ears and nose, including any portion of an artificial arm, leg, foot or hand.
- 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.]

[26.] Reconstructive Procedures

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

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

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998* and women's rights regarding certain health insurance as mandated by District of Columbia, including breast prostheses and treatment of complications at all stages of mastectomy including lymphedemas, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[Rehabilitation Services is variable only for groups that are not required to provide coverage for Essential Health Benefits.]

[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]

[[1]Include when adding Essential Health Benefits.]

[Short-term outpatient rehabilitation services [[1](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.
- [Vision therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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 under this section are not available for maintenance/preventive treatment.

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

[[1]Include when adding Essential Health Benefits.]

[[1]Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- 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. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition 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.
- 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.

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. 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.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.]

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 diagnostic 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*.)

[Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.]

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

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

[29.] 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.

[30.] Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.

- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments..
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

[Include when plan design includes coverage for transitional living services.]

- [Transitional Living services.]

The Mental Health/Substance Use Disorder Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

[31.] Surgery - Outpatient

[[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.]

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]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.

[[1]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*.)

[Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.]

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

[32.] [Temporomandibular Joint Services]

[Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

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

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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

- There is clearly demonstrated radiographic evidence of significant joint abnormality.

- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.]

[33.] Therapeutic Treatments - Outpatient

[Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.]

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*.

[Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.]

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

[34.] 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.

Coverage includes the treatment of breast cancer, lymphoma, and leukemia by dose-intensive chemotherapy or stem cell transplants when performed in accordance with protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, *National Cancer Institute* protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in such procedures.

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

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

[35.] 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*.

[36.] [Virtual Visits]

[Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

[[1]Product and state mandate variable. Include when Non-Network Benefits are available. Standard is to provide these services as network only, however in states that require both network and non-network benefits be available (in products that have a non-network level of benefits) include this "Network" reference.]

[[1]Network] Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

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

Benefits under this section do not include email[,] [or] fax [and standard telephone calls], or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).]

[37.] [Vision Examinations]

[[1]Include when plan design is set up to avoid double coverage for pediatric vision benefits which may be covered under either the Pediatric Vision Care Services Rider or if group is covering them under a stand-alone vision plan.]

[[2]Include when pediatric vision benefits are covered under the Pediatric Vision Care Services Rider.]

[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office [[1]for Covered Persons over the age of [19 - 21].] [[2]Benefits for Covered Persons age [19 - 21] and younger are provided as described in the Pediatric Vision Care Services Rider.]

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

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

[38.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By District of Columbia Law

[39.] Child Health Screenings and Immunizations

Screening tests and immunizations as required by the *Uniform Child Health Screenings and Reporting Form Act of 2004*. Coverage includes but is not limited to, the tests and immunizations listed in the *District of Columbia Child Health Certificate*.

[40.] Habilitative Services

Except for Habilitative Services provided in early intervention and school services, Habilitative Services for children 0 - 21 years old. "Habilitative Services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or Autism Spectrum Disorder, and (b) cerebral palsy.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

[Include bracketed variable exclusions below to support plan design. Unbracketed exclusions will always appear.]

A. Alternative Treatments

1. Acupressure [and acupuncture].
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [Manipulative Treatment and] non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

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

   [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.]

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

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

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech [except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].
6. Oral appliances for snoring.

[The following #7 & 8 apply when benefits are provided for prosthetics.]

[7.] [Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

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

[Applies when benefits are not provided for prosthetics.]

[7.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

D. Drugs

Except as law mandates:

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. This exclusion also does not apply to chemotherapy pills and hormone replacement therapy, for which Benefits are required under District of Columbia insurance law.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

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

[10.] A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

[11.] Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

E. Experimental or Investigational or Unproven Services

Except as law mandates:

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. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

[[1]Applies when plan design does not include benefits for durable medical equipment.]

[[2]Applies when plan design includes benefits for durable medical equipment.]

G. Medical Supplies [[1]and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.
   - [Ostomy supplies.]

   This exclusion does not apply to:
   - [[2]Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]
2. Tubings and masks [[2]except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

[3.] [[1]Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders

Except as law mandates:

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, Neurobiological/Autism Spectrum, and Substance Use Disorder Services* in *Section 1: Covered Health Services.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
4. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

[Applies when plan design does not include coverage for transitional living services.]

[7.] [Transitional Living services.]

I. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is 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.

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 and cold compresses.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.
    - Radios.
    - Saunas.
    - Stair lifts and stair glides.
    - Strollers.
    - Safety equipment.
    - Treadmills.
    - Vehicle modifications such as van lifts.
    - Video players.
    - Whirlpools.

K. Physical Appearance

Except as law mandates:

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.

- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

[6.] [Wigs regardless of the reason for the hair loss.]

L. Procedures and Treatments

Except as law mandates:

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty 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.

[Applies when plan design includes benefits for rehabilitation services.]

[4.] [Rehabilitation services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.]

[Applies when plan design includes benefits for rehabilitation services.]

[5.] [Rehabilitation services for 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.]

[Applies when plan design includes benefits for rehabilitation services.]

[6.] [Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[Applies when plan design does not include benefits for rehabilitation services.]

[4.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy.]

[7.] Psychosurgery.

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

[9.] Biofeedback.

[Applies when plan design does not include benefits for manipulative treatment.]

[10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[Applies when plan design does not include benefits for TMJ.]

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

[Applies when plan design includes benefits for TMJ.]

[11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.]

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

[13.] [Surgical and non-surgical treatment of obesity.] [Non-surgical treatment of obesity.] [Surgical treatment of obesity for open vertical banded gastroplasty and laparoscopic vertical banded gastroplasty.]

[Applies when plan design requires that obesity surgery be received at a Designated Facility. Will only apply when obesity surgery is not available at the non-network benefit level.]

[14.] [Obesity surgery that is not received at a Designated Facility.]

[15.] 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.

[Applies when plan design does not include benefits for breast reduction.]

[16.] [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*.]

[Applies when plan design includes benefits for breast reduction.]

[16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

[Applies when plan design requires that infertility services be received at a Designated Facility. Will only apply when infertility services are not available at the non-network benefit level.]

[17.] [Infertility services that are not received at a Designated Facility.]

[Applies when plan design includes benefits for infertility services.]

[18.] [In vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility.]

[Applies when plan design does not include benefits for infertility services.]

[18.] [In vitro fertilization regardless of the reason for treatment.]

[Applies when plan design requires that implantation of ventricular assist devices be performed at a Designated Facility.]

[19.] [Ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that Network Benefits for implantation of ventricular assist devices be performed at a Designated Facility.]

[20.] [Network Benefits for ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that CHD surgeries be performed at a Designated Facility. Will only apply when CHD surgery is not available at the non-network benefit level.]

[21.] [Congenital Heart Disease surgery that is not performed at a Designated Facility.]

M. Providers

1. Services performed by a provider who is a family member by birth or marriage, [Domestic Partnership] or legal partnership. Examples include a spouse, [Domestic Partner,] legal partner, 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 Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
   - Has not been 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

[Applies when plan design does not include benefits for infertility treatment.]

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.]

[Applies when plan design includes benefits for infertility treatment.]

[The following infertility treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials.
- Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Donor services.]

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

[Applies when plan design does not include benefits for infertility treatment.]

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

[4.] The reversal of voluntary sterilization [and voluntary sterilization].

[5.] [Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [Contraceptive supplies and services.]

[Will not apply when plan design includes benefits for infertility treatment.]

[7.] [Fetal reduction surgery.]

[8.] [Maternity related medical services for Enrolled Dependent children.]

O. Services Provided under another Plan

[Applies when plan design does not include benefits for 24 hour coverage.]

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

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

[Applies when plan design includes benefits for 24 hour coverage.]

   [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy

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

4. Health services while on active military duty.

P. Transplants

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

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

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

[Applies to Network-only plans and to plans with Network and Non-Network benefits when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.]

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

Q. 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.*

R. 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).

S. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

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

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

[4.] [Eye exercise or vision therapy.]

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

[Applies when plan design provides benefits for hearing aids.]

[6.] [Bone anchored hearing aids except when either of the following applies:

- For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.]

[Applies when plan design does not provide benefits for hearing aids.]

[6.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

T. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of school, sports or camp[, travel,] [career or employment,] insurance, marriage, [Domestic Partnership,] legal partnership 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 the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance any deductible, or other amount owed 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. Examination and Autopsy (physical examinations) except when we request it and cover it at our own expense shall have the right and opportunity to examine the Covered Person when and as often as it may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.
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

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

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

[Applies when plan design includes Medicare estimating.]

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Part A, Part B and Part D] [Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

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

[Eligible Persons must reside within the United States.]

[If both spouses [,Domestic Partner] or legal partner are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

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

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

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

[Applies when the Incentives for Health Rider is sold.]

[During this Initial Enrollment Period, the Enrolling Group will offer an incentive plan as described in the [*Incentives for Health*] Rider which is attached to this *Certificate*. In order to enroll in the [*Incentives for Health*] [in subsequent years] you must meet the eligibility requirements stated in the Rider.]

[Open Enrollment Period]

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

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage, legal partnership [, Domestic Partnership].
- Legal guardianship.
- Court or administrative order.
- [Registering a Domestic Partner.]

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Coverage for newborn children begins at the moment of birth and includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. We must receive notification and any required Premium with 31 days of the birth to have coverage continue beyond that 31-day period.

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage, legal partnership [, Domestic Partnership].
- [Registering a Domestic Partner.]

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

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. [Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.]

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). [Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.]

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

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

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

[Throughout this section, select appropriate option for "date" or "last day of the calendar month in which".]

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Other Events Ending Your Coverage

When the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

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

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

  During the first three years the Policy is in effect, 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. After the first three years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

Coverage for a Disabled Dependent Child

Coverage for an unmarried, [not in a Domestic Partnership or] not in a legal partnership 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 Subscriber for support.

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

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

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

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

[Extended Coverage for Total Disability]

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

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

Continuation of Coverage and Conversion

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

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

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

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

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

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

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

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

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

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name 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]]

Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. 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 from the time proof is otherwise required.

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.

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 at the address listed on the back of the Covered Person's ID card or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Payment of Benefits

[Applies when assignment of benefits is agreed to.]

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

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

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

[Applies when assignment of benefits is not agreed to.]

[You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) 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 the 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.]

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

Section 6: Questions, Complaints and Appeals

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

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

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

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

You may also contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process.

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

A Covered Person may also contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

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

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

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

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

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

Grievance and Appeals Process

If you are dissatisfied with the resolution reached through our internal grievance system regarding Medical Necessity, you may contact the:

Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:

District of Columbia Department of Health Care Finance

Office of the Health Care Ombudsman and Bill of Rights

899 North Capital Street, N.E.

6th Floor,

Washington, D.C. 20002

(877)685-6391

Fax: (202) 478-1397

If you are dissatisfied with the resolution reached through our internal grievance system regarding all other grievances, you may contact the *Commissioner* at the following:

For Non-Medical Necessity cases:

Attention: Commissioner

Department of Insurance, Securities and Banking

810 First St. N.E., 7th Floor

Washington, D.C. 20002

202-727-8000

Fax: (202) 354-1085

Urgent Appeals that Require Immediate Action

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

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

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

Federal External Review Program

If you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination.

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

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

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received our decision.

An external review request should include all of the following:

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

An external review will be performed by an *Independent Review Organization (IRO).* We have entered into agreements with three or more *IROs* that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO.*

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

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

After we complete the preliminary review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating claims assignments among the *IROs* or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the *IRO* within ten business days following the date of receipt of the notice additional information that the *IRO* will consider when conducting the external review. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

Upon receipt of a *Final External Review Decision* reversing our determination, we will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* is that payment or referral will not be made, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

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

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

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

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

After we complete the review, we will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IRO*s. We will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned *IRO* will provide written confirmation of the decision to you and to us.

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

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

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

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

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

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

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

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse, [Domestic Partner] or legal partner does, that parent's spouse, [Domestic Partner] or legal partner's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse, [Domestic Partner] or legal partner.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse, [Domestic Partner] or legal partner.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

[Applies when plan design includes Medicare estimating.]

[C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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

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

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

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

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

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may, as we determine, treat the provider’s billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.]

Right to Receive and Release Needed Information

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

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

Payments Made

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

Right of Recovery

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

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

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

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

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

Our Relationship with Providers and Enrolling Groups

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

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

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

The Enrolling Group is solely responsible for all of the following:

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

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

Your Relationship with Providers and Enrolling Groups

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

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

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

Notice

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

Statements by Enrolling Group or Subscriber

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

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, enhanced Benefits, or other incentives to encourage you to participate in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about

whether or not to participate in a program is yours alone. However, we recommend that you discuss participating in such programs with your Physician. Contact us if you have any questions.

Rebates and Other Payments

[[1]Include if rebates are not passed on to the Covered Person. [2]Include if rebates are passed on to the Covered Person.]

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. [[1]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.] [[2]We pass these rebates on to you, and they are applied to any deductible and taken into account in determining your Copayments or Coinsurance.]

Interpretation of Benefits

We have the final authority to do all of the following:

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

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

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

Amendments to the Policy

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

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

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

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

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

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

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

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

[Applies when plan design includes Medicare estimating.]

[Medicare Eligibility]

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

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

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

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

Subrogation and Reimbursement

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

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

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

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

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the final 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 the Policy.
- All or some of the payment was made in error.

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Policy. If the refund is due from a person or organization other than the Covered Person, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which we make payments, pursuant to

a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

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

Limitation of Action

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

Entire Policy

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

Section 9: Defined Terms

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

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

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

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

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

[Applies when plan design includes benefits for infertility services.]

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

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 the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

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

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the *PDLManagement Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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.

[For Pharmaceutical Products, your Copayment is determined by the tier to which the *PDLManagement Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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

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

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

Covered Person - means the Insured and the following persons (if family coverage is chosen), provided coverage has become effective:

The insured's legal spouse; or a party who, with the insured, has entered into a civil union, recognized under District of Columbia law; [or partners in same-sex relationships or Domestic Partnership from other jurisdictions that provide substantially all of the rights and benefits of marriage]; and each of the insured's dependent children (including stepchildren, foster children, those born to or legally adopted and those during any waiting period prior to the finalization of proposed adoption by either the insured or the insured's legal spouse, or the insured's civil union partner [or other partner in the same-sex relationship from another jurisdiction that provides substantially all of the rights and benefits of marriage.] A Dependent includes an unmarried, [not in a Domestic Partnership or] not in a legal partnership child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

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.

[Options related to dependent eligibility are variable based upon the group's benefit plan eligibility rules.]

Dependent - the Subscriber's legal spouse, [Domestic Partner,] legal partner or a child of the Subscriber or the Subscriber's spouse, [Domestic Partner] or legal partner. [All references to the spouse of a Subscriber shall include a [Domestic Partner or] legal partner, except for the purpose of coordinating Benefits with Medicare.] The term child includes any of the following:

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

[The definition of Dependent also includes:

- [Parents of the Subscriber [or the Subscriber's spouse].]

- [Grandparents of the Subscriber [or the Subscriber's spouse.]
- [Any other sponsored Dependents as agreed upon by us and the Enrolling Group].]

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

- A Dependent includes any child listed above under [26 - 30] years of age.
- A Dependent includes an unmarried, not in a [Domestic Partnership or] legal partnership dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the [month] [year] following the date the child reaches age [26 - 30].]

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

A Dependent includes a minor grandchild, niece, or nephew of the Subscriber if the legal guardian is not covered under insurance. To be eligible for coverage under the Policy, the Subscriber must provide food, clothing, and shelter on a regular and continuous basis for the minor during the time that the District of Columbia public schools are in regular session.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

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

[Designated 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 your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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

[Include when Virtual Visits are a standard benefit in Section 1.]

[Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Services via interactive audio and video modalities.]

This is an elective by the employer.

[Domestic Partner - an unmarried, same or opposite sex adult who resides with the Covered Person and has registered in a state or local domestic partner registry with the Covered Person; or your company's requirements.**]**

This is an elective by the employer.

[Domestic Partnership - an unmarried same or opposite sex person who resides with the Subscriber and has registered in a state or local domestic partner registry with a Covered Person, or all of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 16 years of age.
- They must be mentally competent to consent to contract.]

[[1]Applies if group requires documentation of financial interdependence.] This is determined by employer.

- They must be financially interdependent [[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - [They have a single dedicated relationship of at least [6 - 18] months duration.]
  - [They have joint ownership of a residence.]
  - [They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will and/or life insurance policies which designates the other as primary beneficiary].]

[[2]Include if group requires signed affidavit.]

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

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

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

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

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

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

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [An Eligible Person must reside within the United States.]

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity that a person would reasonably expect the absence of immediate medical attention to result in a condition that placed the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or unborn child.

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

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

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

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-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, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

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

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

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

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

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

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

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

Intensive Outpatient Treatment - a structured outpatient mental health or substance-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.]

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, within our discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-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.

The fact that a Physician may prescribe, authorize or direct a service does not itself make it Medically Necessary or covered by the Policy.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our discretion.

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

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

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

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

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

[Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.]

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change.]

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 [by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

[Applies when plan design does not include benefits for new pharmaceutical products.]

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

- The date it is assigned to a tier by our Pharmaceutical Product List Management Committee.

- December 31st of the following calendar year.]

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

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

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

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

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

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

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

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

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.

- The Enrolling Group's application.
- Riders.
- Amendments.

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

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy - includes all of the following:

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

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

[[1]Applies when OB/GYN Physicians are considered Primary Physicians.]

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, [[1]obstetrics/gynecology,] family practice or general medicine.

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

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

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

[Include this statement when any of these Riders are issued as part of the medical plan. Do not include if those products are being sold as stand-alone products or if outpatient prescription drugs have been carved out of the medical plan.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. [(Note that Benefits for [Outpatient Prescription Drugs][,] [and] [Pediatric Vision Care Services] [and] [Pediatric Dental Services], while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.] Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

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.

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change.]

[[Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Savings Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.]

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

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

[[1]Applies when OB/GYN Physicians are considered Primary Physicians.]

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, [[1]obstetrics/gynecology,] family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-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.

[Applies when group purchases extended coverage for total disability.]

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

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

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

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

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

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

Please note:

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

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

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum, including all cost sharing for Essential Health Benefits. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the network out-of-pocket maximum or to remove the network out-of-pocket maximum can only be utilized for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Any variables below that allow the cost shares under the outpatient prescription drug rider to not apply to the out-of-pocket maximum may only be utilized for grandfathered plans, or by non-grandfathered plans that include a separate out-of-pocket drug maximum (which when combined with the medical out-of-pocket maximum may not exceed the annual limitation on cost sharing required under ACA).]

[[1]Product names are variable for possible future product name change]

UnitedHealthcare [[1]Choice]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or PCP.

[[1]Include (and delete all other options 2, 3, 4 and 5) to support prior standard payment method when neither Emergent nor non-Emergent ENRP applies.]

[[1]Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Services.]

[[2]Include and delete #3 if Emergency Health Services provided by a non-Network provider are paid as member hold harmless (Emergent ENRP Option does not apply).]

[[3]Include and delete #2 if Emergency Health Services provided by a non-Network provider are not paid at billed charges (Emergent ENRP Option).]

[[2]Benefits always include Emergency Health Services that are provided by a Network or non-Network provider.]

[[3]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.**]

[[4]Include and delete #5 if non-emergent services by non-network RAPLEs at a network facility are paid as member hold harmless (Non-Emergent ENRP Option does not apply).]

[[5]Include and delete #4 if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP Option).]

[[4]For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Benefits for non-Emergency Covered Health Services include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[5] Covered Health Services that are provided at a Network facility 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.**]

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

[Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible [,] [and] Out-of-Pocket Maximum [,] [and] [Per Occurrence Deductible] requirements as all other Covered Health Services provided by Network providers.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Include when the enhanced benefits for certain procedures/clinical support is sold.]

[You may have an opportunity to received enhanced Benefits for certain procedures received at a Designated Facility and/or by a Designated Physician as described in this *Schedule of Benefits*. You can also determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* the telephone number on your ID card.]

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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

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

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

Prior Authorization

We 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 you are required to obtain prior authorization 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 and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- [Infertility services.]
- [Obesity surgery.]
- 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

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

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

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

Payment Term And Description	Amounts
Annual Deductible	
[Annual deductible is plan design variable. Include applicable provisions to support the following: *[1]Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.* *[2]Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.* *[3]Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.]* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [[1]The Annual Deductible 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 Rider*. [[2]Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[3]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] *[Include applicable provisions to support the following:* *[1]Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* *[2]Carry-over provision applies.* *[3]Roll-over provision applies in any circumstance.* *[4]Roll-over provision applies only to groups changing from calendar to policy year. [5]Include when roll-over applies only to*	*[[1]Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]* *[[2]Include when designated network and network are separate.]* ***[[1]Designated Network and Network]*** ***[[2]Designated Network]*** *[[A] Non-embedded.]* *[[B] Embedded.]* [[A] For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[[2]Network]*** *[[A] Non-embedded.]* *[[B] Embedded.]* [[A] For single coverage, the Annual

Payment Term And Description	Amounts
the individual deductible. *[6Include only when a per occurrence deductible applies.]* [1Amounts 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.] [2Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] [3When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] [4When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [5This roll-over feature applies only to the individual 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. [6The Annual Deductible does not include any applicable Per Occurrence Deductible.] *[Applies when cross accumulation applies to Designated Network and Network Annual Deductible]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.]	Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.]
[Per occurrence deductible is plan design variable.] **[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	[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]

Payment Term And Description	Amounts
Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	
Out-of-Pocket Maximum	
[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following: *[1]Includes the annual deductible.* *[2]Includes the per occurrence deductible.* *[3]Includes copayments.* *[4]Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.]* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]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 Rider*.] *[Include when plan design does not apply all copayments/coinsurance to the OOPM.]* [[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. *[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]* • [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.] *[Include when an Outpatient Prescription Drug Rider is sold*	*[[1]Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]* *[[2]Include when designated network and network are separate.]* ***[[1]Designated Network and Network]*** ***[[2]Designated Network]*** *[[A] Non-embedded.]* *[[B] Embedded.]* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is

Payment Term And Description	Amounts
and copayments/coinsurance do not apply to the overall OOPM.] • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] *[Applies when cross accumulation applies to Designated Network and Network OOPM]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Out-of-Pocket Maximum will be applied to the Network Out-of-Pocket Maximum. Any amount you pay for Covered Health Services that is applied to the Network Out-of-Pocket Maximum will be applied to the Designated Network Out-of-Pocket Maximum.]	covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not

Payment Term And Description	Amounts
	include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[2]Network]*** *[[A] Non-embedded.]* *[[B] Embedded.]* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family

Payment Term And Description	Amounts
	reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No 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.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Payment Term And Description	Amounts
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. [For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.

- Prior authorization requirements and any penalty for failure to prior authorize

- Designated network benefit levels as applicable.

- Any other specific conditions for coverage described within the category.]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

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. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - 5,000] in Eligible Expenses per year.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2-10] visits in a year; [50 - 90]% for any subsequent visits in that year] ***[Network]***	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2-10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
[2.] 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:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport]	[Yes] [No]	[Yes] [No]
	Air Ambulance: [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport]	[Yes] [No]	[Yes] [No]
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport]	[Yes] [No]	[Yes] [No]
	Air Ambulance:		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport]	[Yes] [No]	[Yes] [No]
[3.] 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.)	***[Designated Network]*** [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*.] ***[Network]*** 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.*		
[4.] [Congenital Heart Disease Surgeries]			
[Applies for plan designs that require the use of a designated facility.] **[Prior Authorization Requirement]** [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as the possibility of a congenital heart			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not received at a Designated Facility and performed by a Designated Physician, Benefits will not be paid.]			
[Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] *[Applies for plan designs that require the use of a designated facility.]* [CHD surgeries must be received at a Designated Facility and performed by a Designated Physician.]	[[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]
[6.] Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***[Designated Network]*** [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*.] ***[Network]*** 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 *[Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.]* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.] *[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]* [Benefits for insulin pumps are limited to a single purchase (including repair/replacement) every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* *[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]* ***[Network]*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[7.] [Durable Medical Equipment]			
[Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [[year] [two - five] [years]] [[12 - 60] months].] [This limit does not apply to wound vacuums[, which are limited to a single purchase (including repair/replacement) every [[year] [[two - five] years]] [[12 - 60] months]].] [Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every [three years] [36 months]. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.] [Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months]. Speech aid and tracheo-esophageal voice devices are [not] included in the limits stated above.] [You must purchase or rent the Durable Medical Equipment from the vendor we identify or	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
purchase it directly from the prescribing Network Physician.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[8.] Emergency Health Services - Outpatient			
This includes reimbursement for the cost of one annual voluntary HIV screening test performed on the insured while receiving emergency medical services, other than HIV screening, regardless of necessity, per state mandate. This includes reimbursement of the costs of administering such test, all laboratory expenses to analyze the test, and the costs of communicating to the insured the results of the test and any applicable follow-up. This is not subject to any annual or coinsurance deductible or any copayment other than the copayment that the insured would have to pay for the applicable hospital emergency department visit. **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. *Include only when emergent*	[[50 - 100]%] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit. [If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - 700] for any subsequent visits in that year] [[50 - 100]% after you	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes, after the Per Occurrence Deductible of $[5 - 700] per visit is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
ENRP applies. [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.]**	pay a Copayment of $[5 - 700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - 700] per visit for the next [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[100 - 700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for a condition defined as an Emergency; [50 - 100]% after you pay a Copayment of $[50 - 700] per visit for a condition that does not meet the definition of an Emergency] [After you pay a Copayment of $[5 - 700] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[9.] [Hearing Aids]			
[Limited to $[500 - 5,000] in Eligible Expenses every [year] [12 months].] [Benefits are [further] limited to a single purchase (including repair/replacement) per hearing impaired ear every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]***	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied]
[10.] Home Health Care			
[Limited to [40 - 200] 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.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
[11.] Hospice Care			
	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Network] [50 - 100]%	[Yes] [No]	[Yes] [No]
[12.] Hospital - Inpatient Stay			
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as described below:] • [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
$[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply] [be reduced to $[100 - 1,750].] [The maximum reduction in Copayments is $[10 - 1,000].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a	maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750] [The maximum reduction in Copayments is $[10 - 1,000].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] • [Without clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].] [Ventricular assist device implantation services must be received at a Designated Facility.]			
[13]. [Infertility Services]			
[Prior Authorization Requirement] *[Applies for plans that do NOT require the use of a designated facility. When included remove prior authorization option below.]*			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] *[Applies for plans that require the use of a designated facility. When included remove prior authorization option above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, and as a result infertility services are not received at a Designated Facility and performed by a Designated Physician, Benefits will not be paid.]			
[Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.] [Benefits for Assisted Reproductive Technology (ART) are limited to [one - three] procedure[s] during the entire period of time a Covered Person is enrolled under the Policy.] *[Applies to plan designs that require the use of a designated facility.]* [Infertility services must be received at a Designated Facility and performed by a Designated Physician.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		is satisfied]
	[[50 - 100]% at a freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a Physician office-based	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
X-Ray and Other Diagnostic Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based diagnostic center]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center]		[Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 850] per service]		[Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 850]		[Yes, after the Per Occurrence Deductible of $[5 - 850] per service

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
[16.] Mental Health Services			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[Network]		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] *Outpatient*		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[17.] Neurobiological Disorders - Autism Spectrum Disorder Services			
	[Designated Network]		
	[Inpatient]	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Outpatient]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		satisfied]
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[Network]		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per
	[100% after you pay a Copayment of $[100 -		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Inpatient Stay is satisfied]
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[18.] [Obesity Surgery]			

[Prior Authorization Requirement]

[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization option below.]

[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]

[Applies for plans that do require use of a designated facility. When included remove prior authorization option above.]

[For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, and as a result obesity surgery is not received at a Designated Facility and performed by a Designated Physician, Benefits will not be paid.]

[It is important that you notify us regarding your intention to have surgery. Your notification will

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]			
[Benefits are limited to $[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.] [Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.] *[Applies for plan designs that require the use of a designated facility.]*	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Obesity surgery must be received at a Designated Facility and performed by a Designated Physician.]	[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.] [Ostomy Supplies]			
[Limited to $[500 - 25,000] per year.]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[20.] Pharmaceutical Products - Outpatient			
[The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply,	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]	Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[Designated Network] [[50 - 100]%] [[50 - 100]% for	 [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Covered Health Services from a Primary Physician]		
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
Include only when non-emergent ENRP applies.	***[Network]***		
[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.]** [When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[Include when the enhanced benefits for certain procedures/clinical support is sold.] [When you received certain procedures from a Designated Network Physician, your Benefit will be enhanced as described below:] • [With clinical support, the	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] • [Without clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			
	[Designated Network] *[Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.]* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and**	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	older:] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.]		
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive	***[Network]*** *[Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.]* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
[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 -*	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Outpatient.] • [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 [*and *Manipulative Treatment]*.]]	per visit for any subsequent visits in that year.]		
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes][No]	[Yes][No]
	[50 - 90]% for any subsequent visits in that	[Yes][No]	[Yes][No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes][No]	[Yes][No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes][No]	[Yes][No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes][No]	[Yes][No]
	[50 - 100]% for any subsequent visits in that year.]	[Yes][No]	[Yes][No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[23.] 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.			
	[Designated Network] [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].] ***[Network]*** 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].		
[24.] Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests Note: In accordance with state law, no Copayment and/or Coinsurance or deductible applies to services for screening mammography testing or cervical cytological testing, except for services received in connection with a Physician's office visit. In this case, the Copayment and/or Coinsurance described above under Physician's Office Services - Sickness and Injury will apply.	100%	No	No
Breast pumps	100%	No	No
[25.] [Prosthetic Devices]			
[Benefits are limited to a single purchase of each type of prosthetic device every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			
	[Designated Network] [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*.] *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***[Network]*** 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Limited per year as follows: • [[10 -100] visits of physical therapy.] • [[10 -100] visits of	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150]	[Yes] [No] [Yes, when Benefits are subject to	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 - 100] visits for any combination of physical therapy, occupational therapy and speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]	per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	Coinsurance]	
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]		
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	[Designated Network] [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[Network] [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office [and	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
[Limited to [40 - 180] days per year.] [Limited to: • [[30 - 180] days per year in a Skilled Nursing Facility.] • [Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Services in an Inpatient Rehabilitation Facility are	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
not subject to an annual limit.]	[After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]
[30.] Substance Use Disorder Services			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[Network]		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] *Outpatient*		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[31.] Surgery - Outpatient			
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [$0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[Include when the enhanced benefits for certain procedures/clinical support is sold.] [When you received certain	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
surgical procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%.[The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [Without clinical support, the Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced	Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
to $[100 -750].]] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of service is satisfied]
	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[32.] [Temporomandibular Joint Services]			
	[Designated Network] [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*.] ***[Network]*** [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*.]		
[33.] Therapeutic Treatments -			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Outpatient			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office]] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per treatment]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a freestanding center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-	[Yes] [No]	[Yes] [No]
			[Yes, after the Per

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
[34.] 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.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.] [In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics* -	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Outpatient.] • [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*.]]	20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
[36.] [Virtual Visits]			
[Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	[50 - 100%] [100% after you pay a Copayment of [$5 - 25] per visit]	[Yes]	[Yes] [No]
[37.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] every [[12 - 36] months] [year] [2 - 3 years].]	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[38.] [Wigs]			
[Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [12 - 36] months.]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Additional Benefits Required By District of Columbia Law			
[39.] Child Health Screenings and Immunizations			
	[Designated Network] 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*. ***[Network]*** 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*.		
[40.] Habilitative Services			
Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy *Include when combined therapy visit limits apply.* [Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.]	***[Designated Network]*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit] ***[Network]*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

Eligible Expenses

[[1]Include if either Emergent ENRP or Non-Emergent ENRP applies.]

[[2]Include and delete #3 if non-emergent services by non-network physicians at a network facility are paid at less than billed charges (Non-Emergent ENRP applies) and if emergency health services are paid as member hold harmless (Emergent ENRP does not apply).]

[[3]Include and delete #2 if non-network physicians at a network facility and Emergency Health Services are paid at less than billed charges (Emergent and Non-Emergent ENRP applies).]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [[1]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. [[2]For Covered Health Services provided by a non-Network facility based Physician (other than Emergency Health Services or services otherwise arranged by us), 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 as described below.] [[3]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 *Certificate*.

For [Designated Network Benefits and] Network Benefits, Eligible Expenses are based on the following:

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

[[1]Do not include when Emergent ENRP applies.]

- When Covered Health Services are received from a non-Network provider [[1]as a result of an Emergency or] as arranged by us, Eligible Expenses are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

[Include if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP).]

[**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 - 200]% 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, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance Use Disorder 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.]

Include if Emergency Health Services by non-network physicians or facilities are paid at less than billed charges (Emergent ENRP).

[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 - 200]% 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, 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 and/or a 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.

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.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

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

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

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum, including all cost sharing for Essential Health Benefits. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the network out-of-pocket maximum or to remove the network out-of-pocket maximum can only be utilized for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Any variables below that allow the cost shares under the outpatient prescription drug rider to not apply to the out-of-pocket maximum may only be utilized for grandfathered plans, or by non-grandfathered plans that include a separate out-of-pocket drug maximum (which when combined with the medical out-of-pocket maximum may not exceed the annual limitation on cost sharing required under ACA).]

[[1]Product names are variable for possible future product name change]

UnitedHealthcare [[1]Choice Plus]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

You can choose to receive [Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or PCP.

[Select the applicable option(s) and delete the others. *If either Option #1 or #2 is included, you must delete all other options 3, 4, 5 and 6 to support payment methods available prior to Emergent and Non-Emergent ENRP.]*

[[1]Include if non-network RAPLs at a network facility are paid as network benefits.]

[[1]Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[2]Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

[[2]For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.]

[[3]Include and delete #4 if Emergency Health Services provided by a non-Network provider are paid as network benefits, and member hold harmless (Emergent ENRP Option does not apply).]

[[4]Include and delete #3 if Emergency Health Services provided by a non-Network provider are not paid at billed charges (Emergent ENRP Option).]

[[3]Emergency Health Services are always paid as Network Benefits.]

[[4]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.**]

[[5]Include and delete #6 if non-emergent services by non-network RAPLEs at a network facility are paid as network benefits and member hold harmless (Non-Emergent ENRP Option does not apply).]

[[6]Include and delete #5 if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP Option).]

[[5]For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Benefits for non-Emergency Covered Health Services include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[6]Covered Health Services that are provided at a Network facility 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.**]

[[7]Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as *Out-of-Network Benefits.* [[7]Covered Health Services, when not Emergency Health Services, provided in a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant] will be paid as Non-Network Benefits.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Include when the enhanced benefits for certain procedures/clinical support is sold.]

[You may have an opportunity to received enhanced Benefits for certain procedures received at a Designated Facility and/or by a Designated Physician as described in this *Schedule of Benefits*. You can also determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* the telephone number on your ID card.]

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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

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

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

Prior Authorization

We 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 Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization 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.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card.** This call starts the utilization review process.

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

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 and ground.
- [Breast pumps.]

- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- [Diabetes equipment - insulin pumps [over $[1,000 - 5,000]].]
- [Durable Medical Equipment [over $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Habilitative Services.]
- [Hearing aids [that exceed $[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- [Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.]
- [Lab, X-ray and major diagnostics - CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology.]
- Mental Health Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*.
- [Obesity surgery.]
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]
- [Prosthetic devices [over $[1,000 - 5,000] in cost per device].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].

- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.

[[1]Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

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

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
[Annual deductible is plan design variable. Include applicable provisions to support the following: *[1]Annual deductible applies only to non-network benefits.* *[2]Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.* *[3]Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.* *[4]Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.* *[5]Outpatient Prescription Drug Rider is sold, there is a deductible for designated and/or network benefits and the network and non-network amounts apply to the designated network and network annual deductible.* *[6]Include when Designated Network Benefits apply to any benefit category]* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [[1]Non-Network] Benefits. [[2]The Annual Deductible 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 Rider*. [[3]Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[4]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] [[5]The Annual Deductible for [[6]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the *Outpatient Prescription Drug Rider*.]	*[[1]Include separate network and non-network headings and statements when annual deductible provision applies separately.]* *[[2]Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]* *[[3]Include when designated network and network are separate.]* ***[[1][[2]Designated Network and] Network] [[3]Designated Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[[3]Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible
[Include applicable provisions to support the following: *[1]Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* *[2]Carry-over provision applies.* *[3]Roll-over provision applies in any circumstance.* *[4]Roll-over provision applies only to groups changing from calendar to policy year. [5]Include when roll-over applies only to the individual deductible.*	

Payment Term And Description	Amounts
[6Include only when a per occurrence deductible applies.] [1Amounts 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.] [2Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] [3When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] [4When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [5This roll-over feature applies only to the individual 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. [6The Annual Deductible does not include any applicable Per Occurrence Deductible.] *[Applies when cross accumulation applies to Designated Network and Network Annual Deductible]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.]	is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.][No Annual Deductible.] ***[1Non-Network]*** *[A Non-embedded.]* *[B Embedded.]* [A For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] *[4Include the combined network and non-network heading and statements when annual deductible provision applies separately to combined network and non-network benefits.* *5Include when designated network benefits apply to any category.]* ***[[4[5Designated Network,] Network and Non-Network]*** *[A Non-embedded.]* *[B Embedded.]* [A For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family

Payment Term And Description	Amounts
	coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
[Per occurrence deductible is plan design variable.] **[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	
[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following: *[1]Includes the annual deductible.* *[2]Includes the per occurrence deductible.* *[3]Includes copayments.* *[4]Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.* *[5] Outpatient Prescription Drug Rider is sold, the OOPM applies to designated and/or network benefits and the network and non-network amounts paid under the RX rider apply to the designated network and/or network OOPM.* *[6]Include when Designated Network Benefits apply to any benefit category]* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]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 Rider*.] [[5]The Out-of-Pocket Maximum for [[6]Designated Network and] Network Benefits includes the amount you pay for both	*[[1]Include separate network and non-network headings and statements when OOPM provision applies separately.]* *[[2]Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]* *[[3]Include when designated network and network are separate.]* ***[[1][[2]Designated Network and] Network] [[3]Designated Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.]

Payment Term And Description	Amounts
Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.] *[Include when plan design does not apply all copayments/coinsurance to the OOPM.]* [[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. *[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]* • [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. *[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]* • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] *[Applies when cross accumulation applies to Designated Network and Network OOPM]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Out-of-Pocket Maximum will be applied to the Network Out-of-Pocket Maximum. Any amount you pay for Covered Health Services that is applied to the Network Out-of-Pocket Maximum will be applied to the Designated Network Out-of-Pocket Maximum.]	[[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible,

Payment Term And Description	Amounts
	Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[3]Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance

Payment Term And Description	Amounts
	of $[0 – 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 – 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 – 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 – 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 – 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 – 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 – 45,000] per Covered Person, not to exceed $[0 – 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 – 45,000] per Covered Person, not to

Payment Term And Description	Amounts
	exceed $[0 – 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[1]Non-Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] *[[4]Include combined network and non-network heading and statements below when OOPM provision applies to combined network and non-network benefits and delete the separate "Network" and "Non-Network" provisions above.]*

Payment Term And Description	Amounts
	[5Include when designated network benefits apply to any category.] ***[4[5Designated Network,] Network and Non-Network]*** *A Non-embedded.* *B Embedded.* [A For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [B $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No 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.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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

Payment Term And Description	Amounts
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. [For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.

- Prior authorization requirements and any penalty for failure to prior authorize

- Designated network benefit levels as applicable.

- Any other specific conditions for coverage described within the category.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
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. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - 5,000] in Eligible Expenses per year.] [This limit applies to Network Benefits only. Non-Network Benefits are not available.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	10] visits in a year; [50 - 90]% for any subsequent visits in that year] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]
[2.] 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	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Non-Network*** Same as Network ***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] ***Non-Network*** *Ground Ambulance:* [[50 - 100]%] [Same as Network] [Non-Network Benefits not available] *Air Ambulance:* [[50 - 100]%] [Same as Network] [Non-Network Benefits not available]	Same as Network [Yes] [No] [Yes] [No] [Yes][No] [Same as Network] [Non-Network Benefits not available] [Yes][No] [Same as Network] [Non-Network Benefits not available]	Same as Network [Yes] [No] [Yes] [No] [Yes][No] [Same as Network] [Non-Network Benefits not available] [Yes][No] [Same as Network] [Non-Network Benefits not available]
[3.] Clinical Trials			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
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. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	***[Designated Network]*** [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*.] ***Network*** 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.* ***Non-Network*** 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.*		
[4.] [Congenital Heart Disease Surgeries]			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Prior Authorization Requirement] *[Applies for plan designs that do NOT require the use of a designated facility. When included, remove prior authorization requirements below.]* [For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] *[Applies for plan designs that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included remove the prior authorization requirement above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid.] [[2]Network Benefits will apply] [[2]For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Designated Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] [Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Health Service category in this *Schedule of Benefits*.]			
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[[1]Applies for plan designs that include Network Benefits only and require the use of designated facility. [[1]For Network Benefits, CHD surgeries must be received at a Designated Facility and performed by a Designated Physician.] *[[1]Applies for plan designs that include designated network and non-network benefits.]* [[1]For Designated Network Benefits, CHD surgeries must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician. Non-Network Benefits under this section include only the CHD surgery] *[Applies for plan designs that require the use of a designated facility]* [Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Health Service category in this *Schedule of Benefits*.]			
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
	[Non-Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[100 - 1,000] per day]	[Non-Network Benefits are not available.]	[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		[Non-Network Benefits are not available.]
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Non-Network Benefits are not available.]		
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
	[Non-Network Benefits are not available.]		
[5.] [Dental Services - Accident Only]			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Prior Authorization Requirement] [For [Designated Network,] Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] ***[Non-Network]*** [Same as Network]	[Yes] [No] [Yes] [No] [Same as Network]	[Yes] [No] [Yes] [No] [Same as Network]
[6.] Diabetes Services			
[1 Include when the durable medical equipment benefit is sold.] *[2 Include when the durable medical equipment benefit is not sold.]* **Prior Authorization Requirement** For Non-Network Benefits you must obtain prior authorization before obtaining any [1 Durable Medical Equipment] [2 diabetes equipment] for the management and treatment of diabetes [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***[Designated Network]*** [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*.] ***Network*** Depending upon where the Covered Health Service is provided,		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Diabetes Self-Management Items *Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.] *[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]* [Benefits for insulin pumps are limited to a single purchase (including repair/replacement) every [[year] [[two-five] years]] [[12 - 60] months].]	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*. ***Non-Network*** 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*. ***[Designated Network]*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the Out-of-Pocket Maximum.]] ***Network*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [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*		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Prescription Drug Rider.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[7.] [Durable Medical Equipment]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [[year] [two - five] [years]] [[12 - 60] months].] [This limit does not apply to wound	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
vacuums[, which are limited to a single purchase (including repair/replacement) every [[year] [[two - five] years]] [[12 - 60] months]].] [Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every [three years] [36 months]. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.] [Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months]. Speech aid and tracheo-esophageal voice devices are [not] included in the limits stated above.] [To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
		not available.]	
[8.] Emergency Health Services - Outpatient			
This includes reimbursement for the cost of one annual voluntary HIV screening test performed on the insured while receiving emergency medical services, other than HIV screening, regardless of necessity, per state mandate. This includes reimbursement of the costs of administering such test, all laboratory expenses to analyze the test, and the costs of communicating to the insured the results of the test and any applicable follow-up. This is not subject to any annual or coinsurance deductible or any copayment other than the copayment that the insured would have to pay for the applicable hospital emergency department visit. **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, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. *Include only when emergent*	***Network*** [[50 - 100]%] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit. [If you are admitted as an inpatient to a Network Hospital directly from the Emergency room you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - 700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for the	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes, after the Per Occurrence Deductible of $[5 - 700] per visit is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
ENRP applies. [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.**]	first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - 700] per visit for the next [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[100 - 700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for a condition defined as an Emergency; [50 - 100]% after you pay a Copayment of $[50 - 700] per visit for a condition that does not meet the definition of an Emergency] [After you pay a Copayment of $[5 - 700] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** Same as Network	Same as Network	Same as Network
[9.] [Hearing Aids]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization before obtaining a hearing aid [that exceeds $[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to $[500 - 5,000] in Eligible Expenses every [year] [12 months].] [Benefits are [further] limited to a single purchase	***[Designated Network]*** [[50 - 100]%] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
(including repair/replacement) per hearing impaired ear every [[year] [[two-five] years]] [[12 - 60] months].]	Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Non-Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	Occurrence Deductible of $[50 - 1,000] per device is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied] [Non-Network Benefits are not available.]
[10.] Home Health Care			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [Network Benefits are limited to [40 - 200] visits per year and Non-	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Network Benefits are limited to [40 - 200] 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.]	per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		satisfied]
	Network		
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
	Non-Network		
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
[11.] Hospice Care			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Stay in a hospice facility.]			
	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	Network [50 - 100]%	[Yes] [No]	[Yes] [No]
	Non-Network [50 - 100]%	[Yes] [No]	[Yes] [No]
[12.] Hospital - Inpatient Stay			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as described below:] • [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain*	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
procedures/clinical support is sold.] [When you received certain procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply] [be reduced to $[100 - 1,750].] [The maximum reduction in Copayments is $[10 - 1,000].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750] [The maximum reduction in Copayments is $[10 - 1,000].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] • [Without clinical support, the Coinsurance you pay for the facility charge for services provided at a			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].] [[For Network Benefits, ventricular] [Ventricular] assist device implantation services must be received at a Designated Facility.]	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense]		
[13]. [Infertility Services]			
[Prior Authorization Requirement] *[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization options below.]* [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] *[Required for plans that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included, remove prior authorization option above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, and as a result infertility services are not received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid][[2]Network Benefits will apply.] [[2]For [Network and] Non-Network Benefits, you must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50-90]% of Eligible Expenses][you will be responsible for paying all charges and no Benefit will be paid.]			
[Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.] [Benefits for Assisted Reproductive Technology (ART) are limited to [one - three] procedure[s] during the entire period of time a Covered Person	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
is enrolled under the Policy.] *[[1]Applies to plan designs with Network Benefits only that require the use of designated facility.]* [[1]For Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician.] *[[1]Applies for plan designs that include designated network and non-network benefits]* [[1]For Designated Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician.]	***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement] [For Non-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	of the remaining Eligible Expense] [[50 - 100]% at a freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Network		
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	of the remaining Eligible Expense] [[50 - 100]% at a freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
X-Ray and Other Diagnostic Testing - Outpatient	***[Designated Network]***		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	Network		
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based diagnostic center]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
[Prior Authorization Requirement] [For Non-Network Benefits for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	Occurrence Deductible of $[5 - 850] per service is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center	[Yes] [No] [Yes] [No]	is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Occurrence Deductible of $[5 - 850] per service is satisfied]
	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
[16.] Mental Health Services			

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Designated Network]		
	[Inpatient]	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 – 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 – 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Outpatient]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 – 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 -		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *Outpatient*		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	remaining Eligible Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	will pay [50 - 100]% of the remaining Eligible Expense] *Outpatient* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[17.] Neurobiological Disorders - Autism Spectrum Disorder Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 – 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 – 1,000] per day to a maximum Copayment of $[100 - 10,000] per	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 – 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 – 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 – 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[18.] [Obesity Surgery]			

[Prior Authorization Requirement]

[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization options below.]

[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.] *[Required for plans that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included, remove prior authorization option above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, and as a result obesity surgery is not received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid][[2]Network Benefits will apply] [[2]For [Network and] Non-Network Benefits, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required [Benefits will be reduced to [50-95]% of Eligible Expenses][you will be responsible for paying all charges and no Benefits will be paid.] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[[Any combination of] [Designated Network Benefits] [[,] [and] [Network Benefits] [and Non-Network] Benefits [is] [are] limited to $[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. [Non-Network Benefits are further limited to $[5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]] [Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[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*.]		
[Applies for plan designs with	***[Network]***	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Network Benefits only that require the use of a designated facility.] [For Network Benefits, obesity surgery must be received at a Designated Facility and performed by a Designated Physician.]	[[50 - 100]%]		
	[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*.]		
[Applies for plan designs that include designated network and non-network benefits.] [For Designated Network Benefits, obesity surgery must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician.]	***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
	[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*.] [Non-Network Benefits are not available.]		
[19.] [Ostomy Supplies]			
[Limited to $[500 - 25,000] per year.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are	[Yes] [No] [Non-Network Benefits are not available.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
		not available.]	
[20.] Pharmaceutical Products - Outpatient			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] [For Non-Network Benefits you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical 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.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product]	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 -	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, except when provided during a Physician office visit] [Non-Network Benefits are not available.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] [Non-Network Benefits are not available.]		
[21.] Physician Fees for Surgical and Medical Services			
	[Designated Network] [[50 - 100]%]	 [Yes] [No]	 [Yes] [No]
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include only when non-emergent ENRP applies. [Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses 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.**] [When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.]	Specialist Physician] ***Network*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures from a Designated Network Physician, your Benefit will be enhanced as described below:] • [With clinical support, the Coinsurance you pay for Physician's fees for			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
services provided from a Designated Physician will be reduced to [0-50]%.] • [Without clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
Neither option below will be included with Non-Emergent ENRP.	***Non-Network***		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.] [Covered Health Services			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]**	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a	[Yes][No]	[Yes][No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 -150] per visit for any subsequent visits in that year.]		
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No] [Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.]		
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive	***Network*** *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 –	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	150] per visit for any subsequent visits in that year.]		
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.]		
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[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*	***Non-Network*** *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
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 [*and *Manipulative Treatment]*.]]	Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year. [50 - 90]% for any	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.**]**		
[23.] Pregnancy - Maternity Services			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. **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.**			
	[Designated Network] [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].] ***Network*** 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]. ***Non-Network*** 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].		
[24.] Preventive Care Services			
[Include prior authorization requirement if prior authorization requirements apply. Include penalty statement if a penalty is assessed and select the applicable penalty.] **[Prior Authorization Requirement]** [For Non-Network Benefits, you must obtain prior authorization before obtaining a breast pump. [If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]]			
Physician office services	***Network***		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	100% ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% for immunizations when no other service is provided during the office visit.]	No [Yes] [No] [Yes, when Benefits are subject to Coinsurance]	No [Yes] [No] [Yes, when Benefits are subject to Coinsurance]
Lab, X-ray or other preventive tests	***Network*** 100%	No	No

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Note: In accordance with state law, for Network Benefits, no Copayment and/or Coinsurance or deductible applies to services for screening mammography testing or cervical cytological testing, except for services received in connection with a Physician's office visit. In this case, the Copayment and/or Coinsurance described above under *Physician's Office Services - Sickness and Injury* will apply.	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
Breast pumps	***Network*** 100%	No	No
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100]]	[Yes] [No]	[Yes] [No]
[25.] [Prosthetic Devices]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices [that exceed $[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of each type of prosthetic device every [[year] [[two-five] years]] [[12 - 60] months].] [Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] ***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]
[26.] Reconstructive Procedures			

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]

[Designated Network]

[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*.]

[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]

[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]

Network

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*.

[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]

[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible].

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited per year as follows: • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 - 100] visits for any combination of physical therapy, occupational therapy and speech therapy.] • [[10 -100] visits of	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]]	year]		
[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.] [Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.] [Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
therapy] are limited to [10 - 160] visits per year.]	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	Network [[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100]% of the remaining Eligible Expense] ***Non-Network*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
[Limited to [40 - 180] days per year.] [Limited to: • [[30 - 180] days per year in a Skilled Nursing Facility.] • [Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.] [Network Benefits are limited to [40 - 180] days per year. Non-	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Network Benefits are limited to [40 - 180] days per year.]	Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	$[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[30.] Substance Use Disorder Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.] [100% after you pay a	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 -		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[31.] Surgery - Outpatient			

[[1]Does not apply if prior authorization is required for all pain management.]

[Prior Authorization Requirement]

[For Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [$0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[Include when the enhanced benefits for certain procedures/clinical support is sold.] [When you received certain surgical procedures at a Designated Network Facility, your	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 750].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%.[The Per Occurrence Deductible will [not apply][be reduced to $[100 - 750].]] • [Without clinical support, the Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]]	service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of service is satisfied]
	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 -	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[32.] [Temporomandibular Joint Services]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]			
	[Designated Network] [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*.] ***[Network]*** [Depending upon where the Covered Health Service is provided,		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] [Non-Network Benefits are not available.]		
[33.] Therapeutic Treatments - Outpatient			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	remaining Eligible Expense] [[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	Occurrence Deductible of $[5 - 1,000] per treatment is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[34.] Transplantation Services			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [Non-Network Benefits will apply.] [For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	***Network*** 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.* ***Non-Network*** [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*.] [Non-Network Benefits are not available.]		
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.] [In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [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*.]]	Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
[36.] [Virtual Visits]			
Network] Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling	***[Network]*** [50 - 100%] [100% after you pay a Copayment of [$5 - 25] per visit]	[Yes]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Customer Care at the telephone number on your ID card.	***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[37.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] every [[12 - 36] months] [year] [2-3 years].]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [Non-Network Benefits are not available.]	Coinsurance] [Non-Network Benefits are not available.]	are not available.] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]
[38.] [Wigs]			
[Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [12 - 36] months.]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]

Additional Benefits Required By District of Columbia Law

[39.] State Mandate	
	[Designated Network]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Limited to]	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*. ***Network*** 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*. ***Non-Network*** 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*.		
[40.] Habilitative Services			
Include when notification is required for any habilitative service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [speech therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	***[Designated Network]*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]
Include when combined therapy visit limits apply. [Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.]	***Network*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include when combined therapy visit limits apply separately to network benefits and to non-network benefits. [Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]	***Non-Network*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]

Eligible Expenses

[[1]Include if either Emergent ENRP or Non-Emergent ENRP applies or if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

[[2]Include if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

[[3]Include and delete #4 if non-emergent services by non-network physicians at a network facility are paid at less than billed charges (Non-Emergent ENRP applies) and if emergency health services are paid as member hold harmless (Emergent ENRP does not apply).]

[[4]Include and delete #3 if non-network physicians at a network facility and Emergency Health Services are paid at less than billed charges (Emergent and Non-Emergent ENRP applies).]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [[1]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. [[2]For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by us), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below.] [[3]For Covered Health Services provided by a non-Network facility based Physician (other than Emergency Health Services or services otherwise arranged by us), 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 as described below.] [[4]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.] For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For [Designated Network Benefits and] Network Benefits, Eligible Expenses are based on the following:

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

[[1]Do not include when Emergent ENRP applies.]

- When Covered Health Services are received from a non-Network provider [[1]as a result of an Emergency or] as arranged by us, Eligible Expenses are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[MNRP payment option.]

  - **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, 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 an available gap methodology to determine a rate for the service as follows:
      - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.
      - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
      - When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
    - For Mental Health Services and Substance Use Disorder 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.

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

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

[Include if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP).]

[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 [110-200]% 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, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance Use Disorder 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.**]**

[Include if Emergency Health Services by non-network physicians or facilities are paid at less than billed charges (Emergent ENRP).]

[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.
- [110-200]% 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, 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.**]**

[Traditional OON payment option.]

- **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
  - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - For Mental Health Services and Substance Use Disorder 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.
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
  - When a rate is not published by *CMS* for the service, we use 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.]

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

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

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility and/or a 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.

In both cases, Network 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, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

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

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

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

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum, including all cost sharing for Essential Health Benefits. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the network out-of-pocket maximum or to remove the network out-of-pocket maximum can only be utilized for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Any variables below that allow the cost shares under the outpatient prescription drug rider to not apply to the out-of-pocket maximum may only be utilized for grandfathered plans, or by non-grandfathered plans that include a separate out-of-pocket drug maximum (which when combined with the medical out-of-pocket maximum may not exceed the annual limitation on cost sharing required under ACA).]

[[1]Product name is variable for possible future product name change]

UnitedHealthcare [[1]Options PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

You can choose to receive [Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

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

[Select the applicable option(s) and delete the others. *If either Option #1 or #2 is included, you must delete all other options 3, 4, 5 and 6 to support payment methods available prior to Emergent and Non-Emergent ENRP.]*

[[1]Include if non-network RAPLs at a network facility are paid as network benefits.]

[[1]Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[2]Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

[[2]For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.]

[[3]Include and delete #4 if Emergency Health Services provided by a non-Network provider are paid as network benefits, and member hold harmless (Emergent ENRP Option does not apply).]

[[4]Include and delete #3 if Emergency Health Services provided by a non-Network provider are not paid at billed charges (Emergent ENRP Option).]

[[3]Emergency Health Services are always paid as Network Benefits.]

[[4]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.**]

[[5]Include and delete #6 if non-emergent services by non-network RAPLEs at a network facility are paid as network benefits and member hold harmless (Non-Emergent ENRP Option does not apply).]

[[6]Include and delete #5 if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP Option).]

[[5]For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Benefits for non-Emergency Covered Health Services include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[6]Covered Health Services that are provided at a Network facility 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.**]

[[7]Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as *Out-of-Network Benefits.* [[7]Covered Health Services, when not Emergency Health Services, provided in a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant] will be paid as Non-Network Benefits.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Include when the enhanced benefits for certain procedures/clinical support is sold.]

[You may have an opportunity to received enhanced Benefits for certain procedures received at a Designated Facility and/or by a Designated Physician as described in this *Schedule of Benefits*. You can also determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* the telephone number on your ID card.]

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance

will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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

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

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

Prior Authorization

[[1]Include when network providers are responsible for prior authorization for network benefits.]

We require prior authorization for certain Covered Health Services. [[1]In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization.] Services for which you are required to obtain prior authorization are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

[[1]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.]

When you choose to receive certain Covered Health Services [[1]from non-Network providers], you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card.** This call starts the utilization review process.

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

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 and ground.
- [Breast pumps.]
- Clinical trials.

- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- [Diabetes equipment - insulin pumps [over $[1,000 - 5,000]].]
- [Durable Medical Equipment [over $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Habilitative Services.]
- [Hearing aids [that exceed $[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- [Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.]
- [Lab, X-ray and major diagnostics - CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology.]
- Mental Health Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*.
- [Obesity surgery.]
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]
- [Prosthetic devices [over $[1,000 - 5,000] in cost per device].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary

rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]

- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.

[[1]Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[[1]Include when network providers are responsible for prior authorization for network benefits.]

For all other services, [[1]when you choose to receive services from non-Network providers], we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
[Annual deductible is plan design variable. Include applicable provisions to support the following: *[1]Annual deductible applies only to non-network benefits.* *[2]Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.* *[3]Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.* *[4]Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.* *[5]Outpatient Prescription Drug Rider is sold, there is a deductible for designated and/or network benefits and the network and non-network amounts apply to the designated network and/or network annual deductible.* *[6]Include when Designated Network Benefits apply to any benefit category]* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [[1]Non-Network] Benefits. [[2]The Annual Deductible 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 Rider*. [[3]Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[4]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] [[5]The Annual Deductible for [[6]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the *Outpatient Prescription Drug Rider*.] *[Include applicable provisions to support the following:* *[1]Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* *[2]Carry-over provision applies.* *[3]Roll-over provision applies in any circumstance.* *[4]Roll-over provision applies only to groups changing from calendar to policy year. [5]Include when roll-over applies only to the individual deductible.*	*[[1]Include separate network and non-network headings and statements when annual deductible provision applies separately.]* *[[2]Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]* *[[3]Include when designated network and network are separate.]* ***[[1][[2]Designated Network and] Network] [[3]Designated Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[[3]Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the

Payment Term And Description	Amounts
[6Include only when a per occurrence deductible applies.] [1Amounts 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.] [2Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] [3When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] [4When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [5This roll-over feature applies only to the individual 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. [6The Annual Deductible does not include any applicable Per Occurrence Deductible.] *[Applies when cross accumulation applies to Designated Network and Network Annual Deductible.]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.]	family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[1Non-Network]*** *[A Non-embedded.]* *[B Embedded.]* [A For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] *[4Include the combined network and non-network heading and statements when annual deductible provision applies separately to combined network and non-network benefits.* *5Include when designated network benefits apply to any category.]* ***[4[5Designated Network,] Network and Non-Network]*** *[A Non-embedded.]* *[B Embedded.]* [A For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is

Payment Term And Description	Amounts
	eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
[Per occurrence deductible is plan design variable.] **[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	
[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following: *[1]Includes the annual deductible.* *[2]Includes the per occurrence deductible.* *[3]Includes copayments.* *[4]Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.* *[5]Outpatient Prescription Drug Rider is sold, the OOPM applies to designated and/or network benefits and the network and non-network amounts paid under the RX rider apply to the designated network and/or network OOPM.* *[6]Include when Designated Network Benefits apply to any benefit category]* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]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 Rider*.] [[5]The Out-of-Pocket Maximum for [[6]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug*	*[[1]Include separate network and non-network headings and statements when OOPM provision applies separately.]* *[[2]Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]* *[[3]Include when designated network and network are separate.]* ***[[1][[2]Designated Network and] Network] [[3]Designated Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all

Payment Term And Description	Amounts
Rider.] *[Include when plan design does not apply all copayments/coinsurance to the OOPM.]* [[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. *[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]* • [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. *[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]* • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] *[Applies when cross accumulation applies to Designated Network and Network OOPM]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Out-of-Pocket Maximum will be applied to the Network Out-of-Pocket Maximum. Any amount you pay for Covered Health Services that is applied to the Network Out-of-Pocket Maximum will be applied to the Designated Network Out-of-Pocket Maximum.]	Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to

Payment Term And Description	Amounts
	exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[3]Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[,

Payment Term And Description	Amounts
	except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered

Payment Term And Description	Amounts
	Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[1]Non-Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] *[[4]Include combined network and non-network heading and statements below when OOPM provision applies to combined network and non-network benefits and delete the separate "Network" and "Non-Network" provisions above.]* *[[5]Include when designated network*

Payment Term And Description	Amounts
	benefits apply to any category.] ***[[4][5]Designated Network,] Network and Non-Network]*** *[A Non-embedded.* *[B Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No 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.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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

Payment Term And Description	Amounts
receive certain Covered Health Services. [For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.

- Prior authorization requirements and any penalty for failure to prior authorize

- Designated network benefit levels as applicable.

- Any other specific conditions for coverage described within the category.]

When Benefit limits apply, the limit refers to any combination of ***[Designated Network Benefits,]*** *Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

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. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - 5,000] in Eligible Expenses per year.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	90]% for any subsequent visits in that year] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
[2.] 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	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] ***Non-Network***	[Yes] [No] [Yes] [No] Same as	[Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	Same as Network ***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] ***Non-Network*** *Ground Ambulance:* [[50 - 100]%] [Same as Network] *Air Ambulance:* [[50 - 100]%] [Same as Network]	Network [Yes] [No] [Yes] [No] [Yes][No] [Same as Network]	Same as Network [Yes] [No] [Yes] [No] [Yes][No] [Same as Network]
[3.] 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	***[Designated Network]*** [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*.] ***Network*** Depending upon where the Covered Health Service is provided,		

When Benefit limits apply, the limit refers to any combination of ***[Designated Network Benefits,]*** *Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.* ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
[4.] [Congenital Heart Disease Surgeries]			
[Prior Authorization Requirement] *[Applies for plan designs that do NOT require the use of a designated facility. When included, remove prior authorization requirements below.]* [For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] *[Applies for plan designs that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included remove the prior authorization requirement above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid.] [[2]Network Benefits will apply] *[[3]Include when network providers are responsible for prior authorization for network benefits. [4]Include when covered person is responsible for prior authorization for network benefits.]* [[[3]For Non-Network Benefits you] [[4]You] must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Designated Network Benefits under this section include only the	***[Designated Network]***		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] [Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]	[[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[[1]Applies for plan designs that include Network Benefits only and require the use of designated facility. [[1]For Network Benefits, CHD surgeries must be received at a Designated Facility and performed by a Designated Physician.] *[[1]Applies for plan designs that include designated network and non-network benefits.]* [[1]For Designated Network Benefits, CHD surgeries must be received at a Designated Facility and performed by a Designated	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Physician. Network Benefits include services received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician. Non-Network Benefits under this section include only the CHD surgery] *[Applies for plan designs that require the use of a designated facility]* [Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]	Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement] [For [Designated Network,] Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] ***[Non-Network]*** [Same as Network]	 [Yes] [No] [Yes] [No] [Same as Network]	 [Yes] [No] [Yes] [No] [Same as Network]
[6.] Diabetes Services			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* *[[3]Include when the durable medical equipment benefit is sold.]* *[[4]Include when the durable medical equipment benefit is not sold.]* [[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization before obtaining any [[3]Durable Medical Equipment] [[4]diabetes equipment] for the management and treatment of diabetes [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***[Designated Network]*** [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*.] ***Network*** 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*. ***Non-Network*** 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 *Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.] *[Include only when benefits for durable medical equipment are*	***[Designated Network]*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*.		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
not sold and when benefits for insulin pumps are limited.] [Benefits for insulin pumps are limited to a single purchase (including repair/replacement) every [[year] [[two-five] years]] [[12 - 60] months].]	For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Network*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]*		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the*		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.] [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[7.] [Durable Medical Equipment]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [[year] [two - five] [years]] [[12 - 60] months].] [This limit does not apply to wound vacuums[, which are limited to a single purchase (including repair/replacement) every [[year] [[two - five] years]] [[12 - 60] months]].] [Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every [three years] [36 months]. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.] [Benefits for speech aid devices	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months]. Speech aid and tracheo-esophageal voice devices are [not] included in the limits stated above.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[8.] Emergency Health Services - Outpatient			
This includes reimbursement for the cost of one annual voluntary HIV screening test performed on the insured while receiving emergency medical services, other than HIV screening, regardless of necessity, per state mandate. This includes reimbursement of the costs of administering such test, all laboratory expenses to analyze the test, and the costs of communicating to the insured the results of the test and any applicable follow-up. This is not subject to any annual or coinsurance deductible or any copayment other than the copayment that the insured would have to pay for the applicable hospital emergency department visit. **Note:** If you are confined in a non-Network Hospital after you receive	***Network*** [[50 - 100]%] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit. [If you are admitted as an inpatient to a Network Hospital directly from the Emergency room you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes, after the Per Occurrence Deductible of $[5 - 700] per visit is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
outpatient 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, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. *Include only when emergent ENRP applies.* [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.**]	- 700] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - 700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - 700] per visit for the next [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[100 - 700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - 700] per visit for a condition defined as an Emergency; [50 - 100]% after you pay a Copayment of $[50 - 700] per visit for a condition that does not meet the definition of an Emergency] [After you pay a Copayment of $[5 - 700] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] ***Non-Network*** Same as Network	Same as Network	Same as Network
[9.] [Hearing Aids]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization before obtaining a hearing aid [that exceeds $[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to $[500 - 5,000] in Eligible Expenses every [year] [12 months].] [Benefits are [further] limited to a single purchase (including repair/replacement) per hearing impaired ear every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Non-Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		device is satisfied]
[10.] Home Health Care			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] 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.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network***	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
[11.] Hospice Care			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, [[1]for Non-Network Benefits,] you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	Network [50 - 100]%	[Yes] [No]	[Yes] [No]
	Non-Network [50 - 100]%	[Yes] [No]	[Yes] [No]
[12.] Hospital - Inpatient Stay			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]*			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
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]For Non-Network Benefits for] [[2]For] a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as described below:] • [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply] [be reduced to $[100 - 1,750].] [The maximum reduction in Copayments is $[10 - 1,000].]]	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750] [The maximum reduction in Copayments is $[10 - 1,000].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] • [Without clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].] [[For Network Benefits, ventricular] [Ventricular] assist device implantation services must be received at a Designated			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Facility.]	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
[13]. [Infertility Services]			

[Prior Authorization Requirement]

[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization options below.]

[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[Required for plans that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included, remove prior authorization option above.]

[For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, and as a result infertility services are not received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid][[2]Network Benefits will apply.]

[[2]For [Network and] Non-Network Benefits, you must obtain prior authorization as soon as possible. If you

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
fail to obtain prior authorization as required, [Benefits will be reduced to [50-90]% of Eligible Expenses][you will be responsible for paying all charges and no Benefit will be paid.]			
[Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.] [Benefits for Assisted Reproductive Technology (ART) are limited to [one - three] procedure[s] during the entire period of time a Covered Person is enrolled under the Policy.] *[[1]Applies to plan designs with Network Benefits only that require the use of designated facility.]* [[1]For Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician.] *[[1]Applies for plan designs that include designated network and non-network benefits]* [[1]For Designated Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services received at a Network facility and performed by a Network Physician	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
that is not a Designated Facility and Designated Physician.]			
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits for] [[2]For] sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] [[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Occurrence Deductible of $[5 - 100] per service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] [[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
X-Ray and Other Diagnostic Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits for] [[2]For] CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 850] per service]		[Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[After you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 850] per service at a freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
[16.] Mental Health Services			
Prior Authorization Requirement			
[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]			
[[1]For Non-Network Benefits for] [[2]For] a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, [[1]for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network]		
	[Inpatient]	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Outpatient]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[17.] Neurobiological Disorders - Autism Spectrum Disorder Services			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[1]For Non-Network Benefits for] [[2]For] a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, [[1]for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[18.] [Obesity Surgery]			

[Prior Authorization Requirement]

[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization options below.]

[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]

[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
outcomes for you.] *[Required for plans that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included, remove prior authorization option above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, and as a result obesity surgery is not received at a Designated Facility and performed by Designated Physician, [[1]Benefits will not be paid][[2]Network Benefits will apply] [[2]For [Network and] Non-Network Benefits, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required [Benefits will be reduced to [50-95]% of Eligible Expenses][you will be responsible for paying all charges and no Benefits will be paid.] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[[Any combination of] [Designated Network Benefits] [[,] [and] [Network Benefits] [and Non-Network] Benefits [is] [are] limited to $[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. [Non-Network Benefits are further limited to $[5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]] [Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[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*.]		
[Applies for plan designs with Network Benefits only that require the use of a designated facility.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[For Network Benefits, obesity surgery must be received at a Designated Facility and performed by Designated Physician.]	[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*.]		
[Applies for plan designs that include designated network and non-network benefits.] [For Designated Network Benefits, obesity surgery must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician.]	***[Non-Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[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.] [Ostomy Supplies]			
[Limited to $[500 - 25,000] per year.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[20.] Pharmaceutical Products - Outpatient			
[Prior Authorization Requirement]			
[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]			
[[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical 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.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[Designated Network] [[50 - 100]%] [[50 - 100]% for Covered Health Services from a Primary Physician] [[50 - 100]% for Covered Health Services from a Specialist Physician] ***Network*** [[50 - 100]%]	 [Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No]
Include only when non-emergent ENRP applies. [Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses will be determined as described below under *Eligible*			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
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.**] [When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
provide designation.] **[Enhanced Benefits:]** • [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures from a Designated Network Physician, your Benefit will be enhanced as described below:] • [With clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] • [Without clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] [You can determine the specific procedures for which enhanced Benefits are available by going to			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
Neither option below will be included with Non-Emergent ENRP.	***Non-Network***		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]			
[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]			
	[[50 - 100]% for Covered Health Services from a Primary	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician] [[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	- 10] visits in a year. [50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to	***Network*** *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
$[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.**]**	[Yes] [No]	[Yes] [No]
[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*	***Non-Network*** *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
*Services - Outpatient Therapy [*and *Manipulative Treatment].*]]	Physician office visit and [50 - 100]% for a Specialist Physician office visit]		
	[100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[23.] Pregnancy - Maternity Services			

Prior Authorization Requirement

[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]

[[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
be reduced to [50 - 95]% of Eligible Expenses. **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.**			
	[Designated Network] [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].] ***Network*** 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]. ***Non-Network*** 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].		
[24.] Preventive Care Services			
[Include prior authorization requirement if prior authorization requirements apply. Include penalty statement if a penalty is assessed and select the applicable penalty.] **[Prior Authorization Requirement]** [For Non-Network Benefits, you must obtain prior authorization before obtaining a breast pump. [If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]]			
Physician office services	***Network*** 100% ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 75]	No [Yes] [No] [Yes, when Benefits are subject to Coinsurance]	No [Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% for immunizations when no other service is provided during the office visit.]		
Lab, X-ray or other preventive tests **Note:** In accordance with state law, for Network Benefits no Copayment and/or Coinsurance or deductible applies to services for screening mammography testing or cervical cytological testing, except for services received in connection with a Physician's office visit. In this case, the Copayment and/or Coinsurance described above under *Physician's Office Services - Sickness and Injury* will apply.	***Network*** 100% ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	No [Yes] [No]	No [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Breast pumps	***Network*** 100% ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100]]	No [Yes] [No]	No [Yes] [No]
[25.] [Prosthetic Devices]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization before obtaining prosthetic devices [that exceed $[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of each type of prosthetic device every [[year] [[two-five] years]] [[12 - 60] months].] [Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[26.] Reconstructive Procedures			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]*			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
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]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]			
	[Designated Network] [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*.] *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Network*** 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible].		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited per year as follows: • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 - 100] visits for any combination of physical therapy, occupational therapy and speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.] [Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.] [Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]		
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	Network [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	Non-Network [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the remaining Eligible Expense]		
	[[50 - 100]% at a freestanding center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per date of service at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[29.] Skilled Nursing Facility/Inpatient Rehabilitation			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Facility Services			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits for] [[2]For] a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
[Limited to [40 - 180] days per year.] [Limited to: • [[30 - 180] days per year in a Skilled Nursing Facility.] • [Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.] [Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[50 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	Inpatient Stay is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense]		
[30.] Substance Use Disorder Services			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[1]For Non-Network Benefits for] [[2]For] a scheduled admission for Substance Use Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, [[1]for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the remaining Eligible Expense] *[Outpatient]*		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.]		
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is
	[100% after you pay a		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		satisfied]
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per
	[100% after you pay a Copayment of $[100 -		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Inpatient Stay is satisfied]
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[31.] Surgery - Outpatient			
[[1]Does not apply if prior authorization is required for all pain management.] **[Prior Authorization Requirement]** *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits for] [[2]For] [all outpatient surgeries] [[blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as	***[Designated Network]*** [[50 - 100]%] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
follows:] • [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [$0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[Include when the enhanced benefits for certain procedures/clinical support is sold.] [When you received certain surgical procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]]	Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office]		
• [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]]	[After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
• [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%.[The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]]			
• [Without clinical support, the Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]]			
[You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based surgical center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of	[Yes] [No]	of $[5 - 1,000] per date of service is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the remaining Eligible Expense] [[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[32.] [Temporomandibular Joint Services]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled inpatient admissions.]			
	[Designated Network] [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*.] ***[Network]*** [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*.]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Non-Network] [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*.]		
[33.] Therapeutic Treatments - Outpatient			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a freestanding center or in	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[34.] Transplantation Services			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [Non-Network Benefits will apply.] [For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] *[[1] Include when network providers are responsible for prior authorization for network benefits.]* [In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	***Network*** 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.* ***Non-Network*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.] [In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics -*	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Outpatient.] • [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*.]]	90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
[36.] [Virtual Visits]			
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone	***[Network]*** [50 - 100%] [100% after you pay a Copayment of [$5 - 25] per visit]	[Yes]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
number on your ID card.	***[Non-Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[37.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] every [[12 - 36] months] [year] [2-3 years].]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]		
[38.] [Wigs]			
[Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [12 - 36] months.]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	 [Yes] [No] [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes] [No] [Yes] [No]
Additional Benefits Required By District of Columbia Law			
[39.] Child Health Screenings and Immunizations			
	[Designated Network] 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*. ***Network*** 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*.		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network 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*.		
[40.] Habilitative Services			
Include when notification is required for any habilitative service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [speech therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	*Include when per therapy limits apply.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	*Include when per therapy limits apply.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	*Include when per therapy limits apply.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy
Include when combined therapy visit limits apply. [Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.]	*Include when combined therapy visit limits apply.* [Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.]	*Include when combined therapy visit limits apply.* [Any combination of	*Include when combined therapy visit limits apply.* [Any combination of outpatient habilitative services is limited to [10

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
		outpatient habilitative services is limited to [10 - 160] visits per year.]	- 160] visits per year.]
Include when combined therapy visit limits apply separately to network benefits and to non-network benefits. [Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]	*Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* [Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]	*Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* [Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]	*Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* [Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]

Eligible Expenses

[1 Include if either Emergent ENRP or Non-Emergent ENRP applies or if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

[2 Include if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

[[3]Include and delete #4 if non-emergent services by non-network physicians at a network facility are paid at less than billed charges (Non-Emergent ENRP applies) and if emergency health services are paid as member hold harmless (Emergent ENRP does not apply).]

[[4]Include and delete #3 if non-network physicians at a network facility and Emergency Health Services are paid at less than billed charges (Emergent and Non-Emergent ENRP applies).]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [[1]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. [[2]For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by us), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below.] [[3]For Covered Health Services provided by a non-Network facility based Physician (other than Emergency Health Services or services otherwise arranged by us), 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 as described below.] [[4]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.] For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For [Designated Network Benefits and] Network Benefits, Eligible Expenses are based on the following:

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

[[1]Do not include when Emergent ENRP applies.]

- When Covered Health Services are received from a non-Network provider [[1]as a result of an Emergency or] as arranged by us, Eligible Expenses are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[MNRP payment option.]

  - **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, 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 an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
  - When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- For Mental Health Services and Substance Use Disorder 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.

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

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

[Include if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP).]

[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 [110-200]% 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, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance Use Disorder 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.**]**

[Include if Emergency Health Services by non-network physicians or facilities are paid at less than billed charges (Emergent ENRP).]

[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.
- [110-200]% 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, 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.**]**

[Traditional OON payment option.]

- **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
  - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - For Mental Health Services and Substance Use Disorder 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.
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for*

Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

- When a rate is not published by *CMS* for the service, we use 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.]

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

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

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility and/or a 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.

In both cases, Network 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, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

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

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all cost sharing to apply to the out-of-pocket maximum, including all cost sharing for Essential Health Benefits. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the out-of-pocket maximum or to remove the out-of-pocket maximum can only be utilized for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Any variables below that allow the cost shares under the outpatient prescription drug rider to not apply to the out-of-pocket maximum may only be utilized for grandfathered plans, or by non-grandfathered plans that include a separate out-of-pocket drug maximum (which when combined with the medical out-of-pocket maximum may not exceed the annual limitation on cost sharing required under ACA).]

[[1]Product name is variable for possible future product name change]

UnitedHealthcare [[1]Non-Differential PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level.

We arrange for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

[[1]Include when shared savings program applies.]

Depending on the geographic area and the service you receive, you may have access [[1]through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [[1]when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under a [UnitedHealthcare] Policy.

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

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

Prior Authorization

We require prior authorization for certain Covered Health Services. Services for which you are required to obtain prior authorization are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. 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.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card.** This call starts the utilization review process.

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

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 and ground.
- [Breast pumps.]
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- [Diabetes equipment - insulin pumps [over $[1,000 - 5,000]].]
- [Durable Medical Equipment [over $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Habilitative Services.]
- [Hearing aids [that exceed $[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- [Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.]
- [Lab, X-ray and major diagnostics - CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology.]
- Mental Health Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA).*
- [Obesity surgery.]
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]
- [Prosthetic devices [over $[1,000 - 5,000] in cost per device].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.

[[1]Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

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

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
[Annual deductible is plan design variable. Include applicable provisions to support the following: *[1]Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.* *[2]Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.* *[3]Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [[1]The Annual Deductible 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 Rider*. [[2]Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[3]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] *[Include applicable provisions to support the following:* *[1]Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* *[2]Carry-over provision applies.* *[3]Roll-over provision applies in any circumstance.* *[4]Roll-over provision applies only to groups changing from calendar to policy year. [5]Include when roll-over applies only to the individual deductible.* *[6]Include only when a per occurrence deductible applies.]* [[1]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.] [[2]Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] [[3]When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any	*[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000]. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.]

Payment Term And Description	Amounts
amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] [[4]When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [[5]This roll-over feature applies only to the individual 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. [[6]The Annual Deductible does not include any applicable Per Occurrence Deductible.]	
[Per occurrence deductible is plan design variable.] **[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
[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following: *[1]Includes the annual deductible.* *[2]Includes the per occurrence deductible.* *[3]Includes copayments.* *[4]Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]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 Rider*.] *[Include when plan design does not apply all copayments/coinsurance to the OOPM.]* [[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. *[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]* • [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. *[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]* • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	*[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 -

Payment Term And Description	Amounts
	45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No 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.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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

- The applicable Copayment.
- The Eligible Expense.

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

Payment Term And Description	Amounts
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. [For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.

- Prior authorization requirements and any penalty for failure to prior authorize

- Any other specific conditions for coverage described within the category.]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - 5,000] in Eligible Expenses per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[2.] 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:* [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	Air Ambulance: [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Non-Emergency Ambulance Ground or air ambulance, as we	*Ground Ambulance:* [[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
determine appropriate.	*Air Ambulance:* [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[3.] 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*.	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*.		
[4.] [Congenital Heart Disease Surgeries]			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[6.] Diabetes Services			

[[1] Include when the durable medical equipment benefit is sold.]

[[2] Include when the durable medical equipment benefit is not sold.]

Prior Authorization Requirement

You must obtain prior authorization before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].

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	*[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]*
Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.	[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.]
[Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.]	*[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]*
	[For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*.
[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]	For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]
[Benefits for insulin pumps are limited to a single purchase (including repair/replacement) every [[year] [[two-five] years]] [[12 - 60] months].]	*[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]*
	[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]
	Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.]
	[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]
	[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[7.] [Durable Medical Equipment]			
[Prior Authorization Requirement] [You must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [[year] [two - five] [years]] [[12 - 60] months].] [This limit does not apply to wound vacuums[, which are limited to a single purchase (including repair/replacement) every [[year] [[two - five] years]] [[12 - 60] months]].] [Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every [three years] [36 months]. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.] [Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months]. Speech aid and tracheo-esophageal voice devices are [not] included in the limits stated above.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[8.] Emergency Health Services - Outpatient			
This includes reimbursement for the cost of one annual voluntary HIV screening test performed on the insured while receiving emergency medical services, other than HIV screening, regardless of necessity, per state mandate. This includes reimbursement of the costs of administering such test, all laboratory expenses to analyze the test, and the costs of communicating to the insured the results of the test and any applicable follow-up. This is not subject to any annual or coinsurance deductible or any copayment other than the copayment that the insured would have to pay for the applicable hospital emergency department visit.	[[50 - 100]%] [After you pay a Copayment of $[5 - 700] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 700] per visit is satisfied]
[9.] [Hearing Aids]			
[Prior Authorization Requirement] [You must obtain prior authorization before obtaining a hearing aid [that exceeds $[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to $[500 - 5,000] in Eligible Expenses every [year] [12 months].] [Benefits are [further] limited to a single purchase (including repair/replacement) per hearing impaired ear every [[year] [[two-five] years]] [[12 - 60] months].]	[[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied]
[10.] Home Health Care			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Limited to [40 - 200] 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.]	[[50 - 100]%] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
[11.] Hospice Care			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[12.] Hospital - Inpatient Stay			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	[[50 - 100]%] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
[13]. [Infertility Services]			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.] [Benefits for Assisted Reproductive Technology (ART) are limited to [one - three] procedure[s] during the entire period of time a Covered Person is enrolled under the Policy.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement] [For sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient:	[[50 - 100]%] [[50 - 100]% at a freestanding lab] [[50 - 100]% at a Hospital-based lab] [[50 - 100]% at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
X-Ray and Other Diagnostic Testing - Outpatient:	[[50 - 100]%] [[50 - 100]% at a	[Yes] [No]	[Yes] [No] [Yes, after the Per

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	freestanding diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Occurrence Deductible of $[5 - 100] per service is satisfied]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
[Prior Authorization Requirement] [For CT, PET scans, MRI, MRA, capsule endoscopy, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [[50 - 100]% at a freestanding diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[25 - 850] per service is satisfied]
[16.] Mental Health Services			
Prior Authorization Requirement For a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Inpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	first [2 - 10] visits in a year.]		
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[17.] Neurobiological Disorders - Autism Spectrum Disorder Services			
Prior Authorization Requirement For a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	Inpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[18.] [Obesity Surgery]			
[Prior Authorization Requirement] [You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, you must contact us 24 hours before admission for an Inpatient Stay.]			

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]			
[Benefits are limited to $[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.] [Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.]	[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*.] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[19.] [Ostomy Supplies]			
[Limited to $[500 - 25,000] per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[20.] Pharmaceutical Products - Outpatient			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] [You must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]	Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements. **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician office visit and [50 - 100]% for a Specialist Physician office visit]		
	[100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that	[Yes] [No]	[Yes] [No]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[23.] Pregnancy - Maternity Services			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. **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].		
[24.] Preventive Care Services			

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Include prior authorization requirement if prior authorization requirements apply. Include penalty statement if a penalty is assessed and select the applicable penalty.]			
[Prior Authorization Requirement] [You must obtain prior authorization before obtaining a breast pump. [If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]]			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests Note: In accordance with state law, no Copayment/Coinsurance or deductible applies to services for screening mammography testing or cervical cytological testing, except for services received in connection with a Physician's office visit. In this case, the Coinsurance described above under Physician's Office Services - Sickness and Injury will apply.	100%	No	No
Breast pumps	100%	No	No
[25.] [Prosthetic Devices]			
[Prior Authorization Requirement] [You must obtain prior authorization before obtaining prosthetic devices [that exceed $[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of each type of prosthetic device every [[year] [[two-five] years]] [[12 - 60] months].] [Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			
Prior Authorization Requirement You must obtain prior authorization five business days before a scheduled reconstructive procedure is			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]			
	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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited per year as follows: • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 - 100] visits for any combination of physical therapy, occupational therapy and speech therapy.] • [[10 -100] visits of pulmonary rehabilitation	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a freestanding center] [[50 - 100]% at an outpatient Hospital-based center] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per service is satisfied]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of $[5 - 1,000] per service at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
[Limited to [40 - 180] days per year.] [Limited to: • [[30 - 180] days per year in a Skilled Nursing Facility.] • [Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.]	[[50 - 100]%] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]
[30.] Substance Use Disorder Services			
Prior Authorization Requirement For a scheduled admission for Substance Use Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	Inpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible		

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[31.] Surgery - Outpatient			
[[1]Does not apply if prior authorization is required for all pain management.] **[Prior Authorization Requirement]** [For [all outpatient surgeries] [[blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[10 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an ambulatory surgical center]		
	[[50 - 100]% at an outpatient Hospital-based surgical center]		

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[32.] [Temporomandibular Joint Services]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.]			
	[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*.]		
[33.] Therapeutic Treatments - Outpatient			
[Prior Authorization Requirement] [[2]You must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	freestanding center] [[50 - 100]% at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at a freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[34.] 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 fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. [In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.]	[[50 - 100]%	[Yes] [No]	[Yes] [No]
[36.] [Virtual Visits]			
[Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	[50 - 100%] [100% after you pay a Copayment of [$5 - 25] per visit]	[Yes] [No]	[Yes] [No]
[37.] [Vision Examinations]			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[Limited to [1 exam] [[2-3] exams] every [[12 - 36] months] [year] [2-3 years].]	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]
[38.] [Wigs]			
[Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [12 - 36] months.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Additional Benefits Required By District of Columbia Law

[39.] Child Health Screenings and Immunizations	
	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*.
[40.] Habilitative Services	

Include when notification is required for any habilitative service.

[1]Include applicable Benefit level.

[Pre-service Notification Requirement]

[For Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [speech therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]

Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	*Include when per therapy limits apply.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	*Include when per therapy limits apply.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech	*Include when per therapy limits apply.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
		therapy	

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

Eligible Expenses are based on either of the following:

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

[MNRP payment option.]

- **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
  - Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, 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 an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

        - When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
    - For Mental Health Services and Substance Use Disorder 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.

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

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

[Traditional OON payment option.]

- **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance Use Disorder 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.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
    - When a rate is not published by *CMS* for the service, we use 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.]

      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.

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.

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 and/or a 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.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

_____

(Name and Title)

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [notification] [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.

[[1]Applies when plan design includes the mandatory or restrictive generic program.]

[[2]Applies when plan design includes a therapeutic class charge.]

[[3]Applies when plan design includes a therapeutically equivalent charge.]

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, [[1]Ancillary Charge,] [[2]Therapeutic Class Charge,] [[3]Therapeutically Equivalent Charge,] and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

[Applies when plan design includes the designated pharmacy program. [1]Applies when plan design includes the specialty drug program.]

[Designated Pharmacies]

[If you require certain Prescription Drug Products[1], including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

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

[Smart Fill Program - Split Fill]
[Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Smart Fill Program - 90 Day Supply]
[Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

[Variable provision below supports plan designs that include an annual drug deductible or a specialty prescription drug annual deductible and plan designs that are combined medical/RX plans.]

[[1]Applies when rebates are passed on to customers.]

[[2]Applies when rebates are not passed on to customers.]

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] [or] [Specialty Prescription Drug Product Annual Deductible]]. [[1]We pass [a portion of] [all of] these rebates on to you and they may be [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [and] taken into account in determining your Copayments and/or Coinsurance, or may be shared with you at point of service or in another manner.] [[2]We do not pass these rebates on to you, nor are they [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [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 Rider*. Such business may include, but is not

limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or 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.

Include only when benefits for mail order are sold.

[Maintenance Medication Program]

[If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.]

[Applies when Rider is issued with combined medical and pharmacy deductible plans and when incentive programs apply.]

[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 *Certificate*, 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.]

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents that are provided under *Pharmaceutical Products – Outpatient* in your Certificate of Coverage, regardless of tier placement.

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.

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Section 1: Benefits for Prescription Drug Products

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

[Benefits for contraceptives are variable by plan design.]

[[1]Applies to plan designs that include closed-panel benefits.]

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]. [[1]Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Include when "Refill Too Soon" program applies.

[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.

[Applies to plan designs that include designated pharmacy.]

[If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

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

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

[Applies to plan designs that include mail order.]

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

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

Section 2: Exclusions

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

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

[Variable exclusions below are plan design-specific.]

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.

[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] [Mental Illness] arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

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

[10.] A Pharmaceutical Product for which Benefits are provided in your *Certificate*. [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [This exclusion does not apply to immunizations administered in a [Network] [or] [a Designated] Pharmacy.]

[11.] Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

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

[13.] Unit dose packaging or repackagers of Prescription Drug Products.

[14.] Medications used for cosmetic purposes.

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

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

[17.] [Prescription Drug Products when prescribed to treat infertility.]

[18.] [Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]

[19.] [Treatment for toenail Onychomycosis (toenail fungus).]

[[1]Include for groups not subject to any essential health benefits requirements that purchase benefits for only certain smoking cessation products.]

[20.] [[[1]Certain] Prescription Drug Products for smoking cessation.]

[Include for groups subject to any essential health benefits requirements that are required to cover smoking cessation drugs in order to be PPACA compliant.]

[20.] [Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.]

[Applies when plan design includes closed benefit.]

[21.] [Prescription Drug Products not included on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or] [Tier 5] 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.]

[Applies when plan design includes closed-panel.]

[22]. [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]

[[1]Applies when plan design includes compounds. [2]Applies when plan design excludes compounds.]

[23.] [[1]Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier [2] [3] [4] [5] [6].)] [[2]Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

[[1]Include when a prescription order/refill is required for coverage. [2]Include if group purchases benefits for smoking cessation that include over-the-counter drugs.]

[24.] [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 [[1]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. [[2]This exclusion does not apply to over-the-counter drugs used for smoking cessation.]]

[25.] [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.]

[[1]Applies when plan design excludes growth hormone therapy for all conditions. [2]Applies when plan design includes limited benefits for growth hormone therapy.]

[26.] [[1]Growth hormone therapy.] [[2]Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]

[27.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

[28.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[29.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

[30.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

[31.] [Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.]

[32.] [Prescription Drug Products when prescribed as sleep aids.]

[33.] [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.]

[34.] [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.]

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

[36.] Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

[37.] [A Prescription Drug Product that contains marijuana, including medical marijuana.]

[Include only for groups subject to PPACA essential health benefit benchmark requirements.]

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

[Exclusion does not apply for grandfathered plans]

[39.] [Dental products, including but not limited to prescription fluoride topicals.]

[40.] A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

[41.] Diagnostic kits and products.

[42.] Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

[Variable definitions below are plan design-specific.]

[Applies to plan designs that include the mandatory or restrictive generic program.]

[[1]Applies to the mandatory generic program.]

[**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 [[1]or the provider's] request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.]

[**Annual Drug Deductible** - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] 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.]

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, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

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

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

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, data sources such as medi-span or 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.

[Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[**Infertility Annual Maximum Benefit -** the maximum amount we will pay for covered Prescription Drug Products for Infertility during a year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Annual Maximum Benefit applies.]

[**Infertility Maximum Policy Benefit -** the maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Maximum Policy Benefit applies.]

[[1]Include when plan design includes specialty prescription drug program]

[**List of Preventive Medications -** a list that identifies certain Prescription Drug Products [[1], which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to

reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include only when benefits for mail order are sold.

[Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at [ww.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our periodic review and modification and varies by Therapeutic Class.]

[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.]

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 Mail Order Network Pharmacy - a mail order pharmacy that we identify as a non-preferred pharmacy within the Network.]

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

[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.]

[Preferred Mail Order Network Pharmacy - a mail order pharmacy that we identify as a preferred pharmacy within the Network.]

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

[Applies when plan design includes mail order and MAC pricing.]

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. [The Prescription Drug Charge for a Generic Prescription Drug Product dispensed by a mail order Network Pharmacy, however, will be the Maximum Allowable Cost (MAC) List price which may be higher or lower than the rate we have agreed to pay the mail order Network Pharmacy. We establish the Maximum Allowable Cost (MAC) List price. You may access the amount you will pay for a Brand-name or Generic Prescription Drug Product to be dispensed by a retail Network Pharmacy and/or a mail order Network Pharmacy through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Depending upon your plan design, the amount you will pay may be a Copayment, Coinsurance or the Prescription Drug Charge.]

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 or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only 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.
- [Immunizations administered in a pharmacy.]
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors. [This does not include continuous glucose monitors.]

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice 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 Prescription Drug Charge] [the cost] (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

[Applies if immunizations are covered under the pharmacy benefit:]

- [Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.]
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.]

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

[**Specialty Prescription Drug Product -** Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [Specialty Prescription Drug Products include certain drugs for Infertility.] [Specialty Prescription Drug Products may include

drugs on the List of Preventive Medications.] 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.]

[**Specialty Prescription Drug Product Annual Deductible** - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Specialty Prescription Drug Products in a year before we begin paying for Specialty Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Annual Deductible applies.]

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

[**Therapeutic Class -** a group or category of Prescription Drug Products with similar uses and/or actions.]

[**Therapeutic Class Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class.]

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

[**Therapeutically Equivalent Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is Therapeutically Equivalent to a Prescription Drug Product where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product.]

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.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

_____

(Name and Title)

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [notification] [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.

[[1]Applies when plan design includes the mandatory or restrictive generic program.]

[[2]Applies when plan design includes a therapeutic class charge.]

[[3]Applies when plan design includes a therapeutically equivalent charge.]

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, [[1]Ancillary Charge,] [[2]Therapeutic Class Charge,] [[3]Therapeutically Equivalent Charge,] and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

[Applies when plan design includes the designated pharmacy program. [1]Applies when plan design includes the specialty drug program.]

[Designated Pharmacies]

[If you require certain Prescription Drug Products[1], 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, you will be subject to the non-Network Benefit for that Prescription Drug Product.]

[Smart Fill Program - Split Fill]
[Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Smart Fill Program - 90 Day Supply]
[Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

[Variable provision below supports plan designs that include an annual drug deductible or a specialty prescription drug annual deductible and plan designs that are combined medical/RX plans.]

[[1]Applies when rebates are passed on to customers.]

[[2]Applies when rebates are not passed on to customers.]

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] [or] [Specialty Prescription Drug Product Annual Deductible]]. [[1]We pass [a portion of] [all of] these rebates on to you and they may be [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [and] taken into account in determining your Copayments and/or Coinsurance, or may be shared with you at point of service or in another manner.] [[2]We do not pass these rebates on to you, nor are they [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [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 Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or 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.

Include only when benefits for mail order are sold.

[Maintenance Medication Program]

[If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.]

[Applies when Rider is issued with combined medical and pharmacy deductible plans and when incentive programs apply.]

[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 *Certificate*, 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.]

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents that are provided under *Pharmaceutical Products – Outpatient* in your Certificate of Coverage, regardless of tier placement.

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.

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Section 1: Benefits for Prescription Drug Products

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

[Benefits for contraceptives are variable by plan design.]

[[1]Applies to plan designs that include closed-panel benefits.]

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]. [[1]Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Include when "Refill Too Soon" program applies.

[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.

[Applies to plan designs that include designated pharmacy.]

[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, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.]

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

Prescription Drugs from a Retail Non-Network Pharmacy

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

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

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

[Applies to plan designs that include mail order.]

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

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

Section 2: Exclusions

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

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

[Variable exclusions below are plan design-specific.]

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

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

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

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

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

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

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

[9.] A Pharmaceutical Product for which Benefits are provided in your *Certificate*. [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]

[10.] Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies, 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.] [Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]

[18.] [Treatment for toenail Onychomycosis (toenail fungus).]

[[1]Include for groups not subject to any essential health benefits requirements that purchase benefits for only certain smoking cessation products.]

[19.] [[[1]Certain] Prescription Drug Products for smoking cessation.]

[Include for groups subject to any essential health benefits requirements that are required to cover smoking cessation drugs in order to be PPACA compliant.]

[19.] [Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.]

[Applies when plan design includes closed benefit.]

[20.] [Prescription Drug Products not included on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or] [Tier 5] 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.]

[Applies when plan design includes closed-panel.]

[21]. [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]

[[1]Applies when plan design includes compounds. [2]Applies when plan design excludes compounds.]

[22.] [[1]Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier [2] [3] [4] [5] [6].)] [[2]Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

[[1]Include when a prescription order/refill is required for coverage. [2]Include if group purchases benefits for smoking cessation that include over-the-counter drugs.]

[23.] [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 [[1]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. [[2]This exclusion does not apply to over-the-counter drugs used for smoking cessation.]]

[24.] [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.]

[[1]Applies when plan design excludes growth hormone therapy for all conditions. [2]Applies when plan design includes limited benefits for growth hormone therapy.]

[25.] [[1]Growth hormone therapy.] [[2]Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]

[26.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

[27.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[28.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

[29.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

[30.] [Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.]

[31.] [Prescription Drug Products when prescribed as sleep aids.]

[32.] [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.]

[33.] [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.]

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

[35.] Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

[36.] [A Prescription Drug Product that contains marijuana, including medical marijuana.]

[Include only for groups subject to PPACA essential health benefit benchmark requirements.]

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

[Exclusion does not apply for grandfathered plans.]

[38.] [Dental products, including but not limited to prescription fluoride topicals.]

[39.] A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

[40.] Diagnostic kits and products.

[41.] Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

[Variable definitions below are plan design-specific.]

[Applies to plan designs that include the mandatory or restrictive generic program.]

[[1]Applies to the mandatory generic program.]

[**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 [[1]or the provider's] request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price for non-Network Pharmacies for the Prescription Drug Product, and the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.]

[**Annual Drug Deductible** - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] 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.]

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, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

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

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

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, data sources such as medi-span or 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.

[Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[**Infertility Annual Maximum Benefit -** the maximum amount we will pay for covered Prescription Drug Products for Infertility during a year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Annual Maximum Benefit applies.]

[**Infertility Maximum Policy Benefit -** the maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Maximum Policy Benefit applies.]

[[1]Include when plan design includes specialty prescription drug program]

[**List of Preventive Medications -** a list that identifies certain Prescription Drug Products [[1], which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include only when benefits for mail order are sold.

[Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our periodic review and modification and varies by Therapeutic Class.]

[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.]

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 Mail Order Network Pharmacy - a mail order pharmacy that we identify as a non-preferred pharmacy within the Network.]

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

[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.]

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

[Preferred Mail Order Network Pharmacy - a mail order pharmacy that we identify as a preferred pharmacy within the Network.]

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

[Applies when plan design includes mail order and MAC pricing.]

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. [The Prescription Drug Charge for a Generic Prescription Drug Product dispensed by a mail order Network Pharmacy, however, will be the Maximum Allowable Cost (MAC) List price which may be higher or lower than the rate we have agreed to pay the mail order Network Pharmacy. We establish the Maximum Allowable Cost (MAC) List price. You may access the amount you will pay for a Brand-name or Generic Prescription Drug Product to be dispensed by a retail Network Pharmacy and/or a mail order Network Pharmacy through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Depending upon your plan design, the amount you will pay may be a Copayment, Coinsurance or the Prescription Drug Charge.]

Prescription Drug List - a list that categorizes into tiers medications or products 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 or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only 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.
- [Immunizations administered in a pharmacy.]
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors. [This does not include continuous glucose monitors.]

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice 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 Prescription Drug Charge] [the cost] (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

[Applies if immunizations are covered under the pharmacy benefit:]

- [Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.]
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.]

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

[**Specialty Prescription Drug Product -** Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [Specialty Prescription Drug Products include certain drugs for Infertility.] [Specialty Prescription Drug Products may include drugs on the List of Preventive Medications.] 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.]

[**Specialty Prescription Drug Product Annual Deductible** - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Specialty Prescription Drug Products in a year before we begin paying for Specialty Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Annual Deductible applies.]

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

[**Therapeutic Class -** a group or category of Prescription Drug Products with similar uses and/or actions.]

[**Therapeutic Class Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class. For Prescription Drug Products from non-Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Predominant Reimbursement Rate for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class.]

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

[**Therapeutically Equivalent Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is Therapeutically Equivalent to a Prescription Drug Product where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product. For Prescription Drug Products from non-Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Predominant Reimbursement Rate for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product.]

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.

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum. For non-grandfathered plans that include a separate out-of-pocket drug maximum and/or separate specialty out-of-pocket drug maximum, any combination of the out-of-pocket drug maximum and the specialty drug product out-of-pocket maximum variables and the medical out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the medical out-of-pocket maximum can only be utilized for plans that include a separate medical and prescription drug out-of-pocket maximum or for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans.]

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

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

[Applies to plan designs that include closed-panel benefits. (Closed panel means that we pay only for drugs that are prescribed by a network provider.)]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

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

[Applies when plan design includes open benefit design.]

[[1]Ancillary charge references here and throughout the schedule apply when plan design includes the mandatory or restrictive program.]

[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 [[1]and an Ancillary Charge may apply]. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.]

[Applies when plan design includes closed benefit design.]

[[1]Applies when plan design includes the mandatory or restrictive program.]

[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 [[1]and an Ancillary Charge may apply,] or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.]

[Applies when plan design includes closed-panel benefits.]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

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.

[Variable references here and throughout are used to support either notification or prior authorization requirements.]

[Notification] [Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [notify] [obtain prior authorization from] us or our designee. The reason for [notifying] [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 [notify] [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 [Notification] [Prior Authorization]

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

If [we are not notified] [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 [notification] [prior authorization] are subject to our periodic review and modification. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may determine whether a particular Prescription Drug Product requires [notification] [prior authorization] through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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

[Therapeutic class charge and therapeutically equivalent charge (here and throughout) is variable by plan design.]

When you submit a claim on this basis, you may pay more because you did not [notify] [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] [, Therapeutic Class Charge] [, Therapeutically Equivalent 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 [notification] [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 [notification] [prior authorization], participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

[Step Therapy]

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

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

What You Must Pay

[The following bracketed provisions are variable based upon plan design.]

[You are responsible for paying the [Annual Drug Deductible] [and] [Specialty Prescription Drug Product Annual Deductible].]

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

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

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

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

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

[Benefits for [insulin] [or] [diabetic supplies] 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] [[, in addition to any] [or] Therapeutic Class Charge] [[, in addition to any] [or] Therapeutically Equivalent Charge]. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

[[1]Applies when the plan design includes the mandatory generic program.]

[An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your [[1]or the provider's] request and there is another drug that is Chemically Equivalent. [An Ancillary Charge does not apply to any [Annual Drug Deductible] [,] [Annual Deductible] [,] [Specialty Prescription Drug Product Annual Deductible] [,] [or] [Out-of-Pocket Drug Maximum] [,] [or] [Out-of-Pocket Maximum] [or] [Specialty Prescription Drug Product Out-of-Pocket Maximum].]]

[A Therapeutic Class Charge may apply when the Prescription Drug Charge of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

[A Therapeutically Equivalent Charge may apply when the Prescription Drug Charge of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutically Equivalent Charge and any applicable Copayment and/or Coinsurance.]

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

- [Copayments for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Coinsurance for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Ancillary Charges.]
- [Therapeutic Class Charges.]
- [Therapeutically Equivalent Charges.]
- [The Annual Drug Deductible.]
- [The Specialty Prescription Drug Product Annual Deductible.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.]
- [Certain coupons or offers from pharmaceutical manufacturers. 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.]
- 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 following provisions are plan design variable.]

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

[The Specialty Prescription Drug Product Annual Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Out-of-Pocket Drug Maximums are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

[The Infertility Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Payment Term And Description	Amounts
[Annual Drug Deductible]	
[Annual drug deductible is plan design variable.] *[Option 1: Applies when the annual drug deductible is determined based on network status.]* [The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products.] *[Option 2: Applies when the annual drug deductible is determined based on tier status.]* [The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products.] [Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.] [Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.] [Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.] *[[1]Applies when only the individual portion is subject to the annual drug deductible.]*	*[The variables below correspond with Option 1.]* [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] *[The variables below correspond with Option 2.]* ***[Tier 1]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 2]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 3]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 4]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]

Payment Term And Description	Amounts
[Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [[1]This carry-over feature applies only to the individual Annual Drug Deductible.]] [When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.] *[Applies when the roll-over provision applies to a group changing from a calendar year to policy year plan.]* *[[1]Applies when only the individual portion is subject to the annual drug deductible.]* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual 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 5]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 6]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5] [and] [6]]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[Specialty Prescription Drug Product Annual Deductible]	
[Specialty annual deductible is plan design variable.] *[Option 1: Applies when the specialty*	*[The variable provisions below correspond with Option 1.]* ***[Specialty Prescription Drug Product]*** *[Include when individual specialty prescription drug product deductible*

Payment Term And Description	Amounts
annual deductible is determined based on either specialty prescription drug product, per specialty drug product, per therapeutic class and/or growth hormone therapy.]	*applies.]*
[The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.]	[$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products.] [This does not include any deductible stated below.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [This does not include any deductible stated below.] ***[Specialty - Per Specialty Prescription Drug Product]*** [$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any deductible stated below.] [$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person, not to exceed $[200 - 3,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any deductible stated below.]
[Option 2: Applies when the specialty annual deductible is determined based on tier status.]	***[Specialty - Growth Hormone Therapy]*** [$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] [$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[200 - 3,000] for growth hormone therapy for all Covered Persons in a family.]
[The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.]	***[Specialty - Per Therapeutic Class]*** [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class A.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class B.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class C.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[[1]Applies when only the individual portion of the specialty prescription drug product annual deductible is subject to the carry-over feature.]	*[The variable provisions below correspond with Option 2.]*
[Any amount you pay that is applied to the Specialty Prescription Drug Product Annual Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current year's Specialty Prescription Drug Product Annual Deductible. [[1]This carry-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]] [When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that specialty prescription drug product annual deductible provision of the prior policy will apply to the Specialty Prescription Drug Product Annual Deductible provision under the Policy.]	
[[1]Applies when only the individual portion of the specialty prescription drug	

Payment Term And Description	Amounts
product annual deductible is subject to the roll-over provision for groups changing from a calendar year to policy year plan.] [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Specialty Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Specialty Prescription Drug Product Annual Deductible, will be rolled over and applied to the current Policy year Specialty Prescription Drug Product Annual Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]] [The Specialty Prescription Drug Product Annual Deductible is included in the overall Annual Drug Deductible stated above.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Annual 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 Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 2]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 3]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 4]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 5]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 6]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5] [and] [6]]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[Out-of-Pocket Drug Maximum]	
[Out-of-pocket drug maximum is plan	*[Insert maximum amounts according to benefit design chosen by group.]*

Payment Term And Description	Amounts
design variable. Include applicable provisions to support the following:] *[1The out-of-pocket drug maximum applies annually.]* *[2The annual out-of-pocket drug maximum includes copayments.]* *[3The annual out-of-pocket drug maximum does not include copayments.]* *[4The out-of-pocket drug maximum applies monthly.]* *[5The monthly out-of-pocket drug maximum includes copayments.]* *[6The monthly out-of-pocket drug maximum does not include copayments.]*	*[1Include if copayments and coinsurance are not subject to an out-of-pocket drug maximum.]* *[2Include if copayments and/or coinsurance are subject to an out-of-pocket drug maximum and the benefit design includes an annual drug deductible.]* *[3If an annual drug deductible applies, select the appropriate statement about whether or not the annual drug deductible applies to the out-of-pocket drug maximum.]*
[1The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [2Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [3The Out-of-Pocket Drug Maximum does not include Copayments.]]	*[Include when individual out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person.] *[Include when individual (with family maximum) out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.]
[4The maximum amount you are required to pay for covered Prescription Drug Products in a single calendar month. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [5Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the calendar month. [6The Out-of-Pocket Drug Maximum does not include Copayments.]]	[1Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [2The Out-of-Pocket Drug Maximum [3includes] [3does not include] the Annual Drug Deductible.]
[Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by the Out-of-Pocket Drug Maximum.]	
[Copayments and Coinsurance for covered Prescription Drug Products for Infertility are not limited by the Out-of-Pocket Drug Maximum.]	
[Coupons: We may not permit certain coupons or offers from pharmaceutical	

Payment Term And Description	Amounts
manufacturers to apply to your Out-of-Pocket Drug Maximum. 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.]	
[Specialty Prescription Drug Product Out-of-Pocket Maximum]	
[Specialty out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:] *[1The specialty out-of-pocket drug maximum applies annually.]* *[2The specialty annual out-of-pocket drug maximum includes copayments.]* *[3The specialty annual out-of-pocket drug maximum does not include copayments.]* *[4The specialty out-of-pocket drug maximum applies monthly.]* *[5The specialty monthly out-of-pocket drug maximum includes copayments.]* *[6The specialty monthly out-of-pocket drug maximum does not include copayments.]* [1The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [2Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the year. [3The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]] [4The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single calendar month. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [5Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the	***[Specialty Prescription Drug Product]*** *[Include when individual specialty out-of-pocket maximum applies.]* [$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person.] [This does not include any maximum stated below.] *[Include when individual (with family maximum) specialty out-of-pocket maximum applies.]* [$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [This does not include any maximum stated below.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] ***[Specialty - Per Specialty Prescription Drug Product]*** [$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any maximum stated below.] [$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person, not to exceed $[1,000 - 30,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any maximum stated below.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] ***[Specialty - Growth Hormone Therapy]*** [$[500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[1,000 - 30,000] for growth hormone therapy for all Covered Persons in a family.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]

Payment Term And Description	Amounts
remainder of the calendar month. [[6]The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]] [Copayments and Coinsurance for covered Specialty Prescription Drug Products for Infertility are not limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Out-of-Pocket Maximum. 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.]	***[Specialty - per Therapeutic Class]*** [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]
[Infertility Annual Maximum Benefit]	
[Applicability of infertility annual maximum drug benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.]	[$[250 - 10,000] per Covered Person.]
[Infertility Maximum Policy Benefit]	
[Applicability of infertility maximum	[$[250 - 10,000] per Covered Person.]

Payment Term And Description	Amounts
policy benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.]	
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. *[Include when regimen pricing applies to therapeutic treatments.]* [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 [notification] [prior authorization], participation or activation requirements	*[[1]Applies when our negotiated rate does not apply.]* *[[2]Applies when our negotiated rate applies.]* For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the [[1]lower] [[2]lowest] of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • [[2]The Prescription Drug Charge for that Prescription Drug Product.] [For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product.] See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

Payment Term And Description	Amounts
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. *[Include when Copayment/Coinsurance Waiver Program applies.]* [**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	

Payment Term And Description	Amounts
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)
[The specialty prescription drug product benefit description is plan design variable.] **[Specialty Prescription Drug Products]**	
[The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[Applies when smart fill program applies]* [If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.] Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [,] [or] [a mail order Network Pharmacy] [or] [a Designated Pharmacy].]	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments/coinsurance for growth hormone therapy; differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] [For a Tier 1 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[0-75]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[15-250]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug

Description and Supply Limits	Benefit (The Amount We Pay)
	Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[20-450]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[25-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[25-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[25-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[70-650]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[80-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[80-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[80-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription

Description and Supply Limits	Benefit (The Amount We Pay)
	Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[100-750]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[125-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[125-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[125-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[150-850]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[175-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[175-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not

Description and Supply Limits	Benefit (The Amount We Pay)
	pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Specialty Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
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. *[Applies when plan design includes 90 day generic coverage.]* • [As written by the provider, a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed $[10 - 20].] *[Applies when plan design includes contraceptive benefits.]* • [You may obtain up to 12 cycles of the same contraceptive 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. *[Applies when plan design includes [1]preferred retail network pharmacy and/or [2]non-preferred retail network pharmacy. [3]Applies when plan design includes both preferred and non-preferred retail network pharmacy.]* [We may designate certain retail Network Pharmacies to be [[1]a Preferred Retail Network Pharmacy] [[3]and/or] [[2]a Non-Preferred Retail Network Pharmacy]. We may periodically change	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. 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: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than

Description and Supply Limits	Benefit (The Amount We Pay)
the [[1]Preferred] [[3]and/or] [[2]Non-Preferred] designation of a retail Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a retail Network Pharmacy is a [[1]Preferred Retail Network Pharmacy] [[3]or a] [[2]Non-Preferred Retail Network Pharmacy] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when plan design includes preferred retail network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]* [If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.] *[Applies when plan design includes non-preferred retail network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]* [If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of [0 -	$[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after

Description and Supply Limits	Benefit (The Amount We Pay)
50]% of the Prescription Drug Charge per Prescription Order or Refill.]	you pay a Copayment of $[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-450] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.] *[Include when 90 day generic coverage applies.]* [For a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed $[10 - 20], we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B]

Description and Supply Limits	Benefit (The Amount We Pay)
	[after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription

Description and Supply Limits	Benefit (The Amount We Pay)
	Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you

Description and Supply Limits	Benefit (The Amount We Pay)
	will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
[Applies when plan design includes a mail order benefit.] **[Prescription Drug Products from a Mail Order Network Pharmacy]**	
[The following supply limits apply: *[[1]Applies when plan design includes specialty drug program.]* *[[2]Apply when plan design includes the list of preventive medications.]* • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [[1]These supply limits do not apply to Specialty Prescription Drug Products[[2], including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.] *[Include if plan allows 1x copay at mail.]* [We may allow a 31 day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31 day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[There are two copayment and/or coinsurance options. The first is to tie the number of days' supply to the copayment and/or coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a copayment and/or coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.]* *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 31-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you

Description and Supply Limits	Benefit (The Amount We Pay)
on your ID card.] *[Applies when coverage is initially required at a retail pharmacy prior to using mail order.]* [You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.] *[Applies when initial mail day supply is limited.]* [You may be limited to a 31-day supply for your initial fill and [1 - 3] refill[s] of certain Prescription Drug Products you obtain through a mail order Network Pharmacy.] *[Applies only when mail order Copayments and/or Coinsurance in the right hand column are charged for the full 90 day supply. Does not apply when Copayments and/or Coinsurance are tied to the 31, 60 and 90 day supply.]* [To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.] *[Applies when plan design includes [1]preferred mail order network pharmacy and/or [2]non-preferred mail order network pharmacy. [3]Applies when plan design includes both preferred and non-preferred mail order network pharmacy.]* [We may designate a mail order Network Pharmacy to be [[1]a Preferred Mail Order Network Pharmacy] [[3]and/or] [[2]a Non-Preferred Mail Order Network Pharmacy]. We may periodically change the [[1]Preferred] [[3]and/or] [[2]Non-Preferred] designation of a mail order Network Pharmacy. These changes	will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-

Description and Supply Limits	Benefit (The Amount We Pay)
generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a mail order Network Pharmacy is a [[1]Preferred Mail Order Network Pharmacy] [[3]or a] [[2]non-Preferred Mail Order Network Pharmacy] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when plan design includes preferred mail order network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]* [If you use a Preferred Mail Order Network Pharmacy, your Copayment will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.] *[Applies when plan design includes non-preferred mail order network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]* [If you use a Non-Preferred Mail Order Network Pharmacy, your Copayment will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]	360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-450] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]*

Description and Supply Limits	Benefit (The Amount We Pay)
	[For up to a 60-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-150]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-150]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-150]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-150]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-70]] [you will not pay more than $[70-150]] [you will not pay less than $[7-70] and you will not pay more than $[70-150]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-150]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-70]] [you will not pay more than $[70-150]] [you will not pay less than $[5-70] and you will not pay more than $[70-150]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-500]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-250]] [you will not pay more than $[250-500]] [you will not pay less than $[15-250] and you will not pay more than $[250-500]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-500]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-250]] [you will not pay more than $[250-500]] [you will not pay less than $[10-250] and you will not pay more than $[250-500]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-900]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-900]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-900]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-900]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-450]] [you will not pay more than $[450-900]] [you will not pay less than $[20-450] and you will not pay more than $[450-900]] per Prescription

Description and Supply Limits	Benefit (The Amount We Pay)
	Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-900]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-450]] [you will not pay more than $[450-900]] [you will not pay less than $[15-450] and you will not pay more than $[450-900]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-1,300]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-1,300]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-1,300]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-1,300]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-720]] [you will not pay more than $[720-1,300]] [you will not pay less than $[70-720] and you will not pay more than $[720-1,300]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,300]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-720]] [you will not pay more than $[720-1,300]] [you will not pay less than $[50-720] and you will not pay more than $[720-1,300]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-1,500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-1,500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-1,500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-1,500]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-850]] [you will not pay more than $[850-1,500]] [you will not pay less than $[100-850] and you will not pay more than $[850-1,500]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,500]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-850]] [you will not pay more than $[850-1,500]] [you will not pay less than $[75-850] and you will not pay more than $[850-1,500]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-1,700]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-1,700]]] [,] [and] [[50-

Description and Supply Limits	Benefit (The Amount We Pay)
	100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-1,700]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-1,700]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-1,000]] [you will not pay more than $[1,000-1,700]] [you will not pay less than $[150-1,000] and you will not pay more than $[1,000-1,700]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,700]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-1,000]] [you will not pay more than $[1,000-1,700]] [you will not pay less than $[100-1,000] and you will not pay more than $[1,000-1,700]] per Prescription Order or Refill.]] *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 90-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-225]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-225]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-225]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-225]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-105]] [you will not pay more than $[70-225]] [you will not pay less than $[7-105] and you will not pay more than $[70-225]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-225]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-105]] [you will not pay more than $[70-225]] [you will not pay less than $[5-105] and you will not pay more than $[70-225]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-375]] [you will not pay more than $[250-750]] [you will not pay less than $[15-375] and you will not pay more than $[250-750]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive

Description and Supply Limits	Benefit (The Amount We Pay)
	Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-375]] [you will not pay more than $[250-750]] [you will not pay less than $[10-375] and you will not pay more than $[250-750]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-1,350]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-1,350]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-1,350]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-1,350]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-675]] [you will not pay more than $[450-1,350]] [you will not pay less than $[20-675] and you will not pay more than $[450-1,350]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,350]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-675]] [you will not pay more than $[450-1,350]] [you will not pay less than $[15-675] and you will not pay more than $[450-1,350]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-1,950]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-1,950]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-1,950]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-1,950]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-1,080]] [you will not pay more than $[720-1,950]] [you will not pay less than $[70-1,080] and you will not pay more than $[720-1,950]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,950]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-1,080]] [you will not pay more than $[720-1,950]] [you will not pay less than $[50-1,080] and you will not pay more than $[720-1,950]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-2,250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-2,250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-2,250]]] [,

Description and Supply Limits	Benefit (The Amount We Pay)
	and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-2,250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-1,275]] [you will not pay more than $[850-2,250]] [you will not pay less than $[100-1,275] and you will not pay more than $[850-2,250]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-2,250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-1,275]] [you will not pay more than $[850-2,250]] [you will not pay less than $[75-1,275] and you will not pay more than $[850-2,250]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-2,550]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-2,550]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-2,550]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-2,550]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-1,500]] [you will not pay more than $[1,000-2,550]] [you will not pay less than $[150-1,500] and you will not pay more than $[1,000-2,550]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-2,550]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-1,500]] [you will not pay more than $[1,000-2,550]] [you will not pay less than $[100-1,500] and you will not pay more than $[1,000-2,550]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum. For non-grandfathered plans that include a separate out-of-pocket drug maximum and/or separate specialty out-of-pocket drug maximum, any combination of the out-of-pocket drug maximum and the specialty drug product out-of-pocket maximum variables and the medical out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the medical out-of-pocket maximum can only be utilized for plans that include a separate medical and prescription drug out-of-pocket maximum or for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans.]

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-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.

[Applies to plan designs that include closed-panel benefits. (Closed panel means that we pay only for drugs that are prescribed by a network provider.)]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

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

[Applies when plan design includes open benefit design.]

[[1]Ancillary charge references here and throughout the schedule apply when plan design includes the mandatory or restrictive program.]

[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 [[1]and an Ancillary Charge may apply]. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.]

[Applies when plan design includes closed benefit design.]

[[1]Applies when plan design includes the mandatory or restrictive program.]

[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 [[1]and an Ancillary Charge may apply,] or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.]

[Applies when plan design includes closed-panel benefits.]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

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.

[Variable references here and throughout are used to support either notification or prior authorization requirements.]

[Notification] [Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [notify] [obtain prior authorization from] us or our designee. The reason for [notifying] [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 [notify] [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 [Notification] [Prior Authorization]

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

Non-Network Pharmacy [Notification] [Prior Authorization]

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for [notifying] [obtaining prior authorization from] us as required.

If [we are not notified] [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 [notification] [prior authorization] are subject to our periodic review and modification. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may determine whether a particular Prescription Drug Product requires [notification] [prior authorization] through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If [we are not notified] [you do not obtain prior authorization from us] before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

[Therapeutic class charge and therapeutically equivalent charge (here and throughout) is variable by plan design.]

When you submit a claim on this basis, you may pay more because you did not [notify] [obtain prior authorization from] us before the Prescription Drug Product was dispensed. The amount you are

reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance [, Ancillary Charge] [, Therapeutic Class Charge] [, Therapeutically Equivalent 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 [notification] [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 [notification] [prior authorization], participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

[Step Therapy]

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

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

What You Must Pay

[The following bracketed provisions are variable based upon plan design.]

[You are responsible for paying the [Annual Drug Deductible] [and] [Specialty Prescription Drug Product Annual Deductible].]

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

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

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

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

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

[Benefits for [insulin] [or] [diabetic supplies] 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] [[, in addition to any] [or] Therapeutic Class Charge] [[, in addition to any] [or] Therapeutically Equivalent Charge]. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

[[1]Applies when the plan design includes the mandatory generic program.]

[An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your [[1]or the provider's] request and there is another drug that is Chemically Equivalent. [An Ancillary Charge does not apply to any [Annual Drug Deductible] [,] [Annual Deductible] [,] [Specialty Prescription Drug Product

Annual Deductible] [,] [or] [Out-of-Pocket Drug Maximum] [,] [or] [Out-of-Pocket Maximum] [or] [Specialty Prescription Drug Product Out-of-Pocket Maximum].]]

[A Therapeutic Class Charge may apply when the Prescription Drug Charge or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

[A Therapeutically Equivalent Charge may apply when the Prescription Drug Charge or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutically Equivalent Charge and any applicable Copayment and/or Coinsurance.]

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

- [Copayments for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Coinsurance for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Ancillary Charges.]
- [Therapeutic Class Charges.]
- [Therapeutically Equivalent Charges.]
- [The Annual Drug Deductible.]
- [The Specialty Prescription Drug Product Annual Deductible.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.]
- [Certain coupons or offers from pharmaceutical manufacturers. 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.]
- 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 following provisions are plan design variable.]

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

[The Specialty Prescription Drug Product Annual Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Out-of-Pocket Drug Maximums are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

[The Infertility Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Payment Term And Description	Amounts
[Annual Drug Deductible]	
[Annual drug deductible is plan design variable.] *[Option 1: Applies when the annual drug deductible is determined based on network or non-network status.]* [The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.] *[Option 2: Applies when the annual drug deductible is determined based on tier status.]* [The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.] [Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.] [Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.] [Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of	*[The variables below correspond with Option 1.]* ***[Network]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Non-Network]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Network and Non-Network]*** [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] *[The variables below correspond with Option 2.]* ***[Tier 1]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 2]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]

Payment Term And Description	Amounts
the Annual Drug Deductible.] *[[1]Applies when only the individual portion is subject to the annual drug deductible.]* [Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [[1]This carry-over feature applies only to the individual Annual Drug Deductible.]] [When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.] *[Applies when the roll-over provision applies to a group changing from a calendar year to policy year plan.]* *[[1]Applies when only the individual portion is subject to the annual drug deductible.]* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual 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 3]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 4]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 5]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 6]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5] [and] [6]]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[Specialty Prescription Drug Product	

Payment Term And Description	Amounts
Annual Deductible]	
[Specialty annual deductible is plan design variable.] *[Option 1: Applies when the specialty annual deductible is determined based on either specialty prescription drug product, per specialty drug product, per therapeutic class and/or growth hormone therapy.]* [The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.] *[Option 2: Applies when the specialty annual deductible is determined based on tier status.]* [The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.] *[[1]Applies when only the individual portion of the specialty prescription drug product annual deductible is subject to the carry-over feature.]* [Any amount you pay that is applied to the Specialty Prescription Drug Product Annual Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current year's Specialty Prescription Drug Product Annual Deductible. [[1]This carry-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]] [When a Covered Person was previously covered under a group policy that was replaced by the group Policy,	*[The variable provisions below correspond with Option 1.]* ***[Specialty Prescription Drug Product]*** *[Include when individual specialty prescription drug product deductible applies.]* [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products.] [This does not include any deductible stated below.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [This does not include any deductible stated below.] ***[Specialty - Per Specialty Prescription Drug Product]*** [$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any deductible stated below.] [$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person, not to exceed $[200 - 3,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any deductible stated below.] ***[Specialty - Growth Hormone Therapy]*** [$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] [$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[200 - 3,000] for growth hormone therapy for all Covered Persons in a family.] ***[Specialty - Per Therapeutic Class]*** [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class A.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class B.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for

Payment Term And Description	Amounts
any amount already applied to that specialty prescription drug product annual deductible provision of the prior policy will apply to the Specialty Prescription Drug Product Annual Deductible provision under the Policy.] *[[1]Applies when only the individual portion of the specialty prescription drug product annual deductible is subject to the roll-over provision for groups changing from a calendar year to policy year plan.]* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Specialty Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Specialty Prescription Drug Product Annual Deductible, will be rolled over and applied to the current Policy year Specialty Prescription Drug Product Annual Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]] [The Specialty Prescription Drug Product Annual Deductible is included in the overall Annual Drug Deductible stated above.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Annual 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.]	Therapeutic Class C.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C, not to exceed $[200 - 3,000] for all Covered Persons in a family.] *[The variable provisions below correspond with Option 2.]* ***[Tier 1]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 2]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 3]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 4]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 5]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 6]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5]***

Payment Term And Description	Amounts
	[and] [6]] [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[Out-of-Pocket Drug Maximum]	
[Out-of-pocket drug maximum is plan design variable. Include applicable provisions to support the following:] *[[1]The out-of-pocket drug maximum applies annually.]* *[[2]The annual out-of-pocket drug maximum includes copayments.]* *[[3]The annual out-of-pocket drug maximum does not include copayments.]* *[[4]The out-of-pocket drug maximum applies monthly.]* *[[5]The monthly out-of-pocket drug maximum includes copayments.]* *[[6]The monthly out-of-pocket drug maximum does not include copayments.]* [[1]The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [[2]Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [[3]The Out-of-Pocket Drug Maximum does not include Copayments.]] [[4]The maximum amount you are required to pay for covered Prescription Drug Products in a single calendar month. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [[5]Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the calendar month. [[6]The Out-of-Pocket Drug Maximum does not include Copayments.]] [Copayments and Coinsurance for	*[Insert maximum amounts according to benefit design chosen by group.]* *[[1]Include if copayments and coinsurance are not subject to an out-of-pocket drug maximum.]* *[[2]Include if copayments and/or coinsurance are subject to an out-of-pocket drug maximum and the benefit design includes an annual drug deductible.]* *[[3]If an annual drug deductible applies, select the appropriate statement about whether or not the annual drug deductible applies to the out-of-pocket drug maximum.]* ***[Network]*** *[Include when individual out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person.] *[Include when individual (with family maximum) out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] ***[Non-Network]*** *[Include when individual out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person.] *[Include when individual (with family maximum) out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] *[Include when there is no out-of-pocket drug maximum for non-network benefits.]*

Payment Term And Description	Amounts
covered Specialty Prescription Drug Products are not limited by the Out-of-Pocket Drug Maximum.] [Copayments and Coinsurance for covered Prescription Drug Products for Infertility are not limited by the Out-of-Pocket Drug Maximum.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Out-of-Pocket Drug Maximum. 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.]	[No Out-of-Pocket Drug Maximum] ***[Network and Non-Network]*** *[Include when individual out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person.] *[Include when individual (with family maximum) out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.]
[Specialty Prescription Drug Product Out-of-Pocket Maximum]	
[Specialty out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:] *[[1]The specialty out-of-pocket drug maximum applies annually.]* *[[2]The specialty annual out-of-pocket drug maximum includes copayments.]* *[[3]The specialty annual out-of-pocket drug maximum does not include copayments.]* *[[4]The specialty out-of-pocket drug maximum applies monthly.]* *[[5]The specialty monthly out-of-pocket drug maximum includes copayments.]* *[[6]The specialty monthly out-of-pocket drug maximum does not include copayments.]* [[1]The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [[2]Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the year. [[3]The Specialty Prescription Drug Product Out-of-Pocket Maximum does	***[Specialty Prescription Drug Product]*** *[Include when individual specialty out-of-pocket maximum applies.]* [$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person.] [This does not include any maximum stated below.] *[Include when individual (with family maximum) specialty out-of-pocket maximum applies.]* [$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [This does not include any maximum stated below.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] ***[Specialty - Per Specialty Prescription Drug Product]*** [$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any maximum stated below.] [$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person, not to exceed $[1,000 - 30,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any maximum stated below.] [This Specialty Prescription Drug Product Out-of-Pocket

Payment Term And Description	Amounts
not include Copayments.]] [[4]The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single calendar month. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [[5]Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the calendar month. [[6]The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]] [Copayments and Coinsurance for covered Specialty Prescription Drug Products for Infertility are not limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Out-of-Pocket Maximum. 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.]	Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] ***[Specialty - Growth Hormone Therapy]*** [$[500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[1,000 - 30,000] for growth hormone therapy for all Covered Persons in a family.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] ***[Specialty - per Therapeutic Class]*** [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket

Payment Term And Description	Amounts
	Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]
[Infertility Annual Maximum Benefit]	
[Applicability of infertility annual maximum drug benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.]	[$[250 - 10,000] per Covered Person.]
[Infertility Maximum Policy Benefit]	
[Applicability of infertility maximum policy benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.]	[$[250 - 10,000] per Covered Person.]
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network or non-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. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate. *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. *[Include when regimen pricing applies to therapeutic treatments.]* [We may cover multiple Prescription Drug Products for a single Copayment	*[[1]Applies when our negotiated rate does not apply.]* *[[2]Applies when our negotiated rate applies.]* For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the [[1]lower] [[2]lowest] of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • [[2]The Prescription Drug Charge for that Prescription Drug Product.] [For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product.] See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

Payment Term And Description	Amounts
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 [notification] [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. *[Include when Copayment/Coinsurance Waiver Program applies.]* [**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.]	

Payment Term And Description	Amounts
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. **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)
[The specialty prescription drug product benefit description is plan design variable.] **[Specialty Prescription Drug Products]**	
[The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[Applies when smart fill program applies]* [If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.] Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [,] [or] a non-Network Pharmacy [,] [or] [a mail order Network Pharmacy] [or] [a Designated Pharmacy].]	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments/coinsurance for growth hormone therapy; differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] ***[Network Pharmacy]*** [For a Tier 1 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[0-75]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]]

Description and Supply Limits	Benefit (The Amount We Pay)
	[For a Tier 2 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[15-250]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[20-450]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[25-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[25-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[25-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than

Description and Supply Limits	Benefit (The Amount We Pay)
	$[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[70-650]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[80-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[80-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[80-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[100-750]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[125-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[125-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[125-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you

Description and Supply Limits	Benefit (The Amount We Pay)
	will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[150-850]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[175-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[175-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] ***[Non-Network Pharmacy]*** [For a Tier 1 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[0-75]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Specialty Prescription Drug Product on the List of

Description and Supply Limits	Benefit (The Amount We Pay)
	Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[15-250]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[3][50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[20-450]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[25-450]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[25-450]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[25-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-

Description and Supply Limits	Benefit (The Amount We Pay)
	225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[70-650]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[80-650]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[80-650]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[80-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[100-750]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[125-750]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[125-750]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[125-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[150-850]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[175-850]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[175-850]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Specialty Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the*

Description and Supply Limits	Benefit (The Amount We Pay)
consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. *[Applies when plan design includes 90 day generic coverage.]* • [As written by the provider, a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed $[10 - 20].] *[Applies when plan design includes contraceptive benefits.]* • [You may obtain up to 12 cycles of the same contraceptive 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. *[Applies when plan design includes [1]preferred retail network pharmacy and/or [2]non-preferred retail network pharmacy. [3]Applies when plan design includes both preferred and non-preferred retail network pharmacy.]* [We may designate certain retail Network Pharmacies to be [[1]a Preferred Retail Network Pharmacy] [[3]and/or] [[2]a Non-Preferred Retail Network Pharmacy]. We may periodically change the [[1]Preferred] [[3]and/or] [[2]Non-Preferred] designation of a retail Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a retail Network Pharmacy is a [[1]Preferred Retail Network Pharmacy] [[3]or a] [[2]Non-Preferred Retail Network Pharmacy] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	*following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. 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: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per

Description and Supply Limits	Benefit (The Amount We Pay)
on your ID card.] *[Applies when plan design includes preferred retail network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]* [If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.] *[Applies when plan design includes non-preferred retail network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]* [If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]	Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of

Description and Supply Limits	Benefit (The Amount We Pay)
	$[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-450] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.] *[Include when 90 day generic coverage applies.]* [For a 90-day supply of a Generic for which the Usual and

Description and Supply Limits	Benefit (The Amount We Pay)
	Customary Charge does not exceed $[10 - 20], we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after

Description and Supply Limits	Benefit (The Amount We Pay)
	you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of

Description and Supply Limits	Benefit (The Amount We Pay)
	Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Non-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. *[Applies when plan design includes contraceptive benefits.]* • [A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. 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: [50-100]% of the

Description and Supply Limits	Benefit (The Amount We Pay)
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.	Predominant Reimbursement Rate [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[25-450]]] [,] [and] [[50-100]% of the Predominant Reimbursement

Description and Supply Limits	Benefit (The Amount We Pay)
	Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[25-450]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[25-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[80-650]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[80-650]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[80-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[125-750]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[125-750]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[125-750]]] per Prescription Order or Refill].

Description and Supply Limits	Benefit (The Amount We Pay)
	[[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[175-850]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[175-850]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
[Applies when plan design includes a mail order benefit.] **[Prescription Drug Products from a Mail Order Network Pharmacy]**	
[The following supply limits apply: *[1 Applies when plan design includes specialty drug program.]* *[2 Apply when plan design includes the*	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of*

Description and Supply Limits	Benefit (The Amount We Pay)
list of preventive medications.] • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [[1]These supply limits do not apply to Specialty Prescription Drug Products[[2], including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.] *[Include if plan allows 1x copay at mail.]* [We may allow a 31 day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31 day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when coverage is initially required at a retail pharmacy prior to using mail order.]* [You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.] *[Applies when initial mail day supply is limited.]* [You may be limited to a 31-day supply for your initial fill and [1 - 3] refill[s] of certain Prescription Drug Products you obtain through a mail order Network Pharmacy.] *[Applies only when mail order Copayments and/or Coinsurance in the*	*preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[There are two copayment and/or coinsurance options. The first is to tie the number of days' supply to the copayment and/or coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a copayment and/or coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.]* *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 31-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a

Description and Supply Limits	Benefit (The Amount We Pay)
right hand column are charged for the full 90 day supply. Does not apply when Copayments and/or Coinsurance are tied to the 31, 60 and 90 day supply.] [To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.] *[Applies when plan design includes [1]preferred mail order network pharmacy and/or [2]non-preferred mail order network pharmacy. [3]Applies when plan design includes both preferred and non-preferred mail order network pharmacy.]* [We may designate a mail order Network Pharmacy to be [[1]a Preferred Mail Order Network Pharmacy] [[3]and/or] [[2]a Non-Preferred Mail Order Network Pharmacy]. We may periodically change the [[1]Preferred] [[3]and/or] [[2]Non-Preferred] designation of a mail order Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a mail order Network Pharmacy is a [[1]Preferred Mail Order Network Pharmacy] [[3]or a] [[2]non-Preferred Mail Order Network Pharmacy] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when plan design includes preferred mail order network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]* [If you use a Preferred Mail Order Network Pharmacy, your Copayment will be reduced by a minimum of $[1 -	Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]]

Description and Supply Limits	Benefit (The Amount We Pay)
60] per Prescription Order or Refill.] [If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.] *[Applies when plan design includes non-preferred mail order network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]* [If you use a Non-Preferred Mail Order Network Pharmacy, your Copayment will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]	[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-450] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more

Description and Supply Limits	Benefit (The Amount We Pay)
	than $[500-850]] per Prescription Order or Refill.]] *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 60-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-150]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-150]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-150]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-150]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-70]] [you will not pay more than $[70-150]] [you will not pay less than $[7-70] and you will not pay more than $[70-150]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-150]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-70]] [you will not pay more than $[70-150]] [you will not pay less than $[5-70] and you will not pay more than $[70-150]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-500]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-250]] [you will not pay more than $[250-500]] [you will not pay less than $[15-250] and you will not pay more than $[250-500]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-500]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-250]] [you will not pay more than $[250-500]] [you will not pay less than $[10-250] and you will not pay more than $[250-500]] per Prescription Order or Refill.]]

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	[For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-900]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-900]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-900]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-900]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-450]] [you will not pay more than $[450-900]] [you will not pay less than $[20-450] and you will not pay more than $[450-900]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-900]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-450]] [you will not pay more than $[450-900]] [you will not pay less than $[15-450] and you will not pay more than $[450-900]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-1,300]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-1,300]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-1,300]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-1,300]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-720]] [you will not pay more than $[720-1,300]] [you will not pay less than $[70-720] and you will not pay more than $[720-1,300]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,300]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-720]] [you will not pay more than $[720-1,300]] [you will not pay less than $[50-720] and you will not pay more than $[720-1,300]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-1,500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-1,500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for

Description and Supply Limits	Benefit (The Amount We Pay)
	Therapeutic Class [B] [after you pay a Copayment of $[100-1,500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-1,500]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-850]] [you will not pay more than $[850-1,500]] [you will not pay less than $[100-850] and you will not pay more than $[850-1,500]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,500]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-850]] [you will not pay more than $[850-1,500]] [you will not pay less than $[75-850] and you will not pay more than $[850-1,500]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-1,700]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-1,700]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-1,700]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-1,700]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-1,000]] [you will not pay more than $[1,000-1,700]] [you will not pay less than $[150-1,000] and you will not pay more than $[1,000-1,700]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,700]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-1,000]] [you will not pay more than $[1,000-1,700]] [you will not pay less than $[100-1,000] and you will not pay more than $[1,000-1,700]] per Prescription Order or Refill.]] *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 90-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-225]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-225]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-225]]] [, and] [[50-100]% of the Prescription Drug Charge for a

Description and Supply Limits	Benefit (The Amount We Pay)
	Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-225]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-105]] [you will not pay more than $[70-225]] [you will not pay less than $[7-105] and you will not pay more than $[70-225]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-225]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-105]] [you will not pay more than $[70-225]] [you will not pay less than $[5-105] and you will not pay more than $[70-225]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-375]] [you will not pay more than $[250-750]] [you will not pay less than $[15-375] and you will not pay more than $[250-750]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-375]] [you will not pay more than $[250-750]] [you will not pay less than $[10-375] and you will not pay more than $[250-750]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-1,350]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-1,350]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-1,350]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-1,350]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-675]] [you will not pay more than $[450-1,350]] [you will not pay less than $[20-675] and you will not pay more than $[450-1,350]] per Prescription Order or Refill.]]

Description and Supply Limits	Benefit (The Amount We Pay)
	[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,350]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-675]] [you will not pay more than $[450-1,350]] [you will not pay less than $[15-675] and you will not pay more than $[450-1,350]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-1,950]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-1,950]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-1,950]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-1,950]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-1,080]] [you will not pay more than $[720-1,950]] [you will not pay less than $[70-1,080] and you will not pay more than $[720-1,950]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,950]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-1,080]] [you will not pay more than $[720-1,950]] [you will not pay less than $[50-1,080] and you will not pay more than $[720-1,950]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-2,250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-2,250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-2,250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-2,250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-1,275]] [you will not pay more than $[850-2,250]] [you will not pay less than $[100-1,275] and you will not pay more than $[850-2,250]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-2,250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-1,275]] [you will not pay more than $[850-2,250]] [you will not pay less than $[75-1,275] and you will not pay

Description and Supply Limits	Benefit (The Amount We Pay)
	more than $[850-2,250]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-2,550]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-2,550]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-2,550]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-2,550]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-1,500]] [you will not pay more than $[1,000-2,550]] [you will not pay less than $[150-1,500] and you will not pay more than $[1,000-2,550]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-2,550]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-1,500]] [you will not pay more than $[1,000-2,550]] [you will not pay less than $[100-1,500] and you will not pay more than $[1,000-2,550]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]

UnitedHealthcare Insurance Company

[Performance Rewards] Amendment

As described in this Amendment, the Policy is modified to address calculation of the Policy Charge under [Performance Rewards].

Article 3.4 of the Policy is replaced with the following:

3.4 Payment of the Policy Charge

[Variable provisions apply when advance payment is supported in Exhibit 1.]

The Policy Charge is payable to us [in advance] by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1 and as described under [Performance Rewards] below. [The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.]

All payments will be made in United States dollars, in immediately available funds, and will be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked “paid in full”, “without recourse”, or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

[[1] Include when grace period provision applies.]

[[2] Include when grace period provision does not apply.]

A late payment charge will be assessed for any Policy Charge not received [[1]within [10 - 45] calendar days following the due date.] [[2]by the due date.] A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

The following defined terms are added to Article 1 of the Policy:

Article 1: Glossary of Defined Terms

Adjusted Policy Charge - the greater of: (a) the Policy Charge Due for the Policy year and (b) four times the Policy Charge Due for the last three calendar months of the Policy year.

[Insert the number of months that Performance Rewards is to be in effect (standard is 12, but could range from a minimum of 6 to a maximum of 18)].

Agreement Period - [6-18] consecutive months beginning with the effective date.

Experience Refund - the amount determined by us to be due to the Enrolling Group for readjustment of the rate of Premium for the Policy based on the expense experience under the Policy, and according to the calculations set forth under the *Experience Refund Calculations* provision below, in the form of a Policy Charge credit.

Experience Refund Report - the document that we will prepare and deliver to the Enrolling Group containing details on Policy Charge Due, Policy Charge Paid, Total Expenses and any refund due.

Policy Charge Due - the sum of Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy due from the Enrolling Group as calculated by us according to our records.

Policy Charge Paid - the sum of Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy due from and paid by the Enrolling Group for a Policy year as calculated by us according to our records.

Total Expenses - the sum of all expenses incurred by us on behalf of Covered Persons during the Policy year, as calculated by us. Total Expenses will be calculated by adding the following amounts:

[[1]Insert the Administration Fee]

- *Retention* - a charge of [[1]00]% of the Policy Charge Due for a Policy year in consideration of: (i) the administrative services provided pursuant to the Policy; (ii) any premium tax or other governmental charge; and (iii) the risk for the Experience Refund assumed by us.
- *Incurred Eligible Expenses* - Eligible Expenses incurred during a Policy year, which will be determined as (1) plus (2) minus (3) as follows:

[[1]Applies when limit per covered person is included (pooling point). When included, the 'pooling" definition below applies.]

(1) Eligible Expenses paid during a Policy year, irrespective of the date they are incurred[[1],up to a limit of $[00] for any Covered Person].

[[1]Insert the % of the current year's Adjusted Policy Charge that will be held for claim reserve.]

(2) [[1]00]% of the Adjusted Policy Charge for a Policy year.

[[1]Insert % of the prior year's Adjusted Policy Charge that was held for claim reserve. If New Business, enter "0%".]

(3) [[1]00]% of the Adjusted Policy Charge for the prior Policy year (but $0 if the Policy year is the initial Policy year).

[[1]Applies when a pooling charge is included. [2]Applies when charge is per covered person per month. [3]Applies when charge is a percentage of the policy charge due.]

- [[1]*Pooling* - A charge of [[2]$[00] per Covered Person per month] [[3][00]% of the Policy Charge Due] for the Policy Year in consideration of the limitation on the liability of the Enrolling Group for Eligible Expenses as calculated above.]

Article 7: Performance Rewards is added to the Policy:

Article 7: Performance Rewards

Experience Refund Calculations

The following formulas will be used to calculate any Experience Refund due:

- Policy Charge Paid minus Total Expenses equals the excess amount of Policy Charge Paid.

[[1]Insert % of the excess amount that is credited. The standard is 50%.

[2]Insert the maximum % of the Policy Charge due that will be credited. The standard is 8%.]

- Experience Refund equals the lesser of: (a) [[1]0-100]% multiplied by the excess amount of Policy Charge Paid and (b) [[2]0-100]% of the Policy Charge Due.

The Experience Refund will be calculated by us in accordance with the following terms:

- In the event Total Expenses equal or exceed the Policy Charge Paid, no Experience Refund will be made.

- In the event the Policy Charge Paid exceeds Total Expenses, no Experience Refund will be made if the Policy has been terminated by either us or the Enrolling Group prior to the end of a Policy year or by the Enrolling Group at the time the Experience Refund Report is delivered.
- In the event the Policy Charge Paid exceeds Total Expenses, an Experience Refund will be made in the form of a Policy Charge credit. The Policy Charge credit will be applied to one or more of the Policy Charge statements which become due after the date the Experience Refund Report is delivered.

Experience Refund Report

We will prepare and deliver to the Enrolling Group an Experience Refund Report containing details on Policy Charge Due, Policy Charge Paid, Total Expenses and any refund due. Such report will be delivered within 120 days following the last day of the Policy year. The Experience Refund Report will contain details regarding the method used by us to make any refund due.

Termination

Termination

Performance Rewards may be terminated in any of the following ways:

- If the Policy terminates, Performance Rewards will automatically terminate at the same time; provided however, that the Enrolling Group will be entitled to any outstanding Experience Refund if the Enrolling Group is then subsequently contracted with us for an administrative services only (self-funded) arrangement for medical benefits similar to those provided under this Policy.
- Performance Rewards may be terminated upon any mutually agreed upon date.

Relationship of Experience Refund to Receipt of Benefits

The amount of any Experience Refund made in accordance with the terms of Performance Rewards will bear no relationship to the frequency or extent of Benefits furnished to any specific Covered Person, but will be based only on the Eligible Expenses for Benefits paid for all Covered Persons under the Policy during the Policy year.

Contract Issuance: Include Effective Date only if Amendment is to be mailed separate from the Policy. Do not include effective date when amendment is issued as part of the Policy.

[Effective Date of this Amendment: _____]

_____

(Name and Title)

UnitedHealthcare Insurance Company

Catalyst Rider

[NOTE: Product name filed as variable to allow name change in future.]

This Rider to the Policy provides a limited amount of Benefits that you can access prior to meeting the Annual Deductible requirement stated in the *Schedule of Benefits*. [Catalyst Rider Benefits are available only to [the Subscriber] [Enrolled Dependents] and any reference to "you" in this Rider is a reference to [the Subscriber] [Enrolled Dependents].]

Catalyst Rider Benefits

[Calendar year or Policy year are variable by plan design.]

Catalyst Rider Benefits are available to you on a [calendar] [Policy] year basis.

[Designated network benefit provision is variable by plan design.]

[Non-network benefit provision is variable by plan design.]

[1 Include only when these services will have a separate annual maximum from other Rider benefits.]

[2 Include when routine care services are included along with ambulance and emergency in the separate annual maximum.]

We will pay $[50 - 5,000] in [Catalyst] Benefits per Covered Person in a single year for Covered Health Services identified below that are received from a [Designated Network] [,] [or] Network [or non-Network] provider before you are responsible for meeting the Annual Deductible stated in the *Schedule of Benefits*. [The total amount of Catalyst Rider Benefits is further limited to $[100 - 10,000] in a single year for all Covered Persons in a family.] [1 **Ambulance Services** and **Emergency Health Services - Outpatient** [2 and routine care services] are not included in this annual maximum, but are instead subject to a separate maximum. [2 Routine care services are Covered Health Services described under the following Benefit categories: **Lab, X-Ray and Diagnostics - Outpatient, Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services, Physician's Office Services - Sickness and Injury, Substance Use Disorder Services and Urgent Care Center Services**]. We will pay $[100 - 7,000] per Covered Person per year in Catalyst Rider Benefits for any combination of **Ambulance Services** and **Emergency Health Services - Outpatient** described below [2 and we will pay [$50 - 5,000] per Covered Person per year in Rider Benefits for routine care services. Routine care services are limited to the Covered Health Services described under the following Benefit categories: **Lab, X-Ray and Diagnostics - Outpatient, Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services, Physician's Office Services - Sickness and Injury, Substance Use Disorder Services and Urgent Care Center Services**].]

After Catalyst Rider Benefits have been exhausted, you must then meet the Annual Deductible before we begin to pay Benefits as described in the *Schedule of Benefits*.

[Copayments/coinsurance applicability toward the annual deductible is variable by plan design.]

The amount that you pay for Catalyst Rider Benefits in Copayments or Coinsurance will [not] be applied toward the Annual Deductible stated in the *Schedule of Benefits.*

The amount that you pay for Catalyst Rider Benefits in Copayments and Coinsurance will [not] be applied toward the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Benefits for Covered Health Services that are subject to day or visit limits as stated in the *Schedule of Benefits* are reduced by any days or visits paid as Catalyst Rider Benefits. Benefits for Covered Health Services that are subject to dollar limits as stated in the *Schedule of Benefits* are not reduced by any dollars paid as Catalyst Rider Benefits.

Covered Health Services to which Catalyst Rider Benefits apply are listed below and are described in *Section 1: Covered Health Services* of the *Certificate of Coverage.*

[Include service categories and benefit statements to support plan design.]

[Ambulance Services]

[[1]Include when plan includes non-network benefits. Delete if issued with a network only plan.]

[Emergency Ambulance]

[We will pay Benefits as stated in the *Schedule of Benefits* for either ground or air ambulance. [[1]Benefits for Emergency ambulance services by a non-Network provider are payable as Network Benefits.]]

[[2]Include as applicable when plan design for any non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[Non-Emergency Ambulance]

[We will pay Benefits as stated in the *Schedule of Benefits* for either ground or air ambulance.]

[[2]Benefits for non-Emergency ambulance services by a non-Network provider are payable as Network Benefits.]

[[2]For Non-Network Benefits for non-Emergency ambulance services, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits for non-Emergency ambulance services, Non-Network Benefits are not available.]

[Clinical Trials]

[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 Rider.]

[Congenital Heart Disease Surgeries]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Dental Services - Accident Only]

[[1]Include when plan includes non-network benefits. Delete if issued with a network only plan.]

[We will pay Benefits as stated in the *Schedule of Benefits*. [[1]Benefits for services by a non-Network provider are payable as Network Benefits.]]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.[3]Non-network benefit are payable as network benefits.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[3]Benefits for services by a non-Network provider are payable as Network Benefits.]]

[Diabetes Services]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Durable Medical Equipment]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Emergency Health Services - Outpatient]

[[1]Include if plan design supports applying a copayment or coinsurance different from the underlying plan.]

[[2]Include if plan design supports applying a copayment.]

[[3]Include if the copayment will be waived if admitted directly from the ER.]

[[4]Include if plan design is based on the underlying plan.]

[[5]Include when plan includes non-network benefits. Delete if issued with a network only plan.]

[[[1]We will pay [50 - 100]% of Eligible Expenses [[2]after you pay a Copayment of $[5 - 300] per visit [however if the Emergency Health Service is a Mental Health or Substance Use Disorder Emergency Health Service, we will pay 100% of Eligible Expenses]. [[3]If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will

not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [[4]We will pay Benefits as stated in the *Schedule of Benefits*.] [[5]Benefits for Emergency Health Services by a non-Network provider are payable as Network Benefits.]]

[Hearing Aids]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[Home Health Care]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Hospice Care]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Hospital - Inpatient Stay]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Lab, X-Ray and Diagnostics - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Designated Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

[[2]Non-Network Benefits are not available.]

[Mental Health Services]

[Inpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]Include if plan design supports applying separate individual/group copayments.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]]

[[4]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[Neurobiological Disorders - Autism Spectrum Disorders]

[Inpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]Include if plan design supports applying separate individual/group copayments.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]]

[[4]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[Ostomy Supplies]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]*Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]*

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[Pharmaceutical Products - Outpatient]

[[1]*Include when the plan design is based on the underlying plan.]*

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]*Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]*

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[Physician Fees for Surgical and Medical Services]

[[1]*Include when the plan design is based on the underlying plan.]*

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]*Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]*

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Physician's Office Services - Sickness and Injury]

[[1]*Include when the plan design is based on the underlying plan.]*

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]Include if plan design supports applying a split copayment.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]

[[5]Include when covered health services performed in a physician's office are subject to the copayments/coinsurance stated under other benefit categories, in addition to the office visit copayment stated in this section. (This will not apply when the office visit benefit is subject to coinsurance only.)]

[[5]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 [and Manipulative Treatment]*.]]

[Pregnancy - Maternity Services]

[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 Rider.]

[Prosthetic Devices]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[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 Rider.]

[Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when Plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]

[[2]Non-Network Benefits are not available.]

[Scopic Procedures - Outpatient Diagnostic and Therapeutic]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Skilled Nursing Facility/Inpatient Rehabilitation Facility Services]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Substance Use Disorder Services]

[Inpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]Include if plan design supports applying separate individual/group copayments.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[Surgery - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Therapeutic Treatments - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Transplantation Services]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design does not include a non-network level of benefits.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Non-Network Benefits are not available.]

[Urgent Care Center Services]

[[1]Include when rider benefits apply only to network benefits and if plan design supports applying a copayment or coinsurance different from the underlying plan. [2]Include if plan design supports applying a copayment.]

[[1]We will pay [50 - 100]% of Eligible Expenses [[2]after you pay a Copayment of $[5 - 150] per visit].]

[[3]Include when rider benefits apply to both network and non-network benefits and if plan design supports applying a copayment or coinsurance different from the underlying plan.]

[[4]Include when plan includes non-network benefits. Delete if issued with a network only plan.]

[[3]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[2]after you pay a Copayment of $[5 - 150] per visit]. [[4]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[4]after you pay a Copayment of $[5 - 150] per visit].]]

[[4]Include when the plan design is based on the underlying plan.]

[[4]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[5]Include when covered health services performed in an urgent care center are subject to the copayments/coinsurance stated under other benefit categories, in addition to the urgent care copayment stated in this section. (This will not apply when the urgent care center benefit is subject to coinsurance only.)]

[[5]In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:

- [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*.]

[Virtual Visits]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design does not include a non-network level of benefits.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Non-Network Benefits are not available.]

[[1]Include when first dollar benefits are limited both per person and per family. This option is available only when rider benefits are available to all covered persons.]

Catalyst Rider Benefits apply only to the current year. If you [[1]or all Covered Persons in your family] do not use the total amount of Catalyst Rider Benefits available in a single year, the remaining amount of Catalyst Rider Benefits will not be carried over to the next year.

_____

(Name and Title)

State: District of Columbia
Filing Company: UnitedHealthcare Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: 2017 UHIC Large Group Forms
Project Name/Number: /

Supporting Document Schedules

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Flesch Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Statement of Variabilities
Comments:	
Attachment(s):	SOV-SBN17-INS-2011-Pharmacy Network-LG-DC.pdf SOV-SBN17-Medical-INS-2011-Choice Plus-LG-DC.pdf SOV-SBN17-Medical-INS-2011-Choice-LG-DC.pdf SOV-SBN17-Medical-INS-2011-NonDifferential-LG-DC.pdf SOV-SBN17-Medical-INS-2011-Options-LG-DC.pdf SOV-COC17-INS-2011-LG-DC.pdf SOV-Performance Rewards-2011-INS-LG-DC.pdf SOV-Rider17-INS-2011-Pharmacy Network and Non-Network-LG-DC.pdf SOV-Rider17-INS-2011-Pharmacy Network-LG-DC.pdf SOV-SBN17-INS-2011-Pharmacy Network and Non-Network-LG-DC.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlines to previously approved forms
Comments:	
Attachment(s):	SBN17-Medical-INS-2011-Choice-LG-DC - redline.pdf SBN17-Medical-INS-2011-NonDifferential-LG-DC - redline.pdf SBN17-Medical-INS-2011-Options-LG-DC - redline.pdf SBN17-Pharmacy-INS-2011-Pharmacy Network and Non-Network-DC - redline.pdf SBN17-Pharmacy-INS-2011-Pharmacy Network-LG-DC - redline.pdf COC17-INS-2011-LG-DC - redline.pdf Rider17-INS-2011-Catalyst-LG-DC - redline.pdf Rider17-INS-2011-Pharmacy Network-LG-DC - redline.pdf Rider17-INS-2011-Pharmacy Network-LG-DC - redline.pdf SBN17-Medical-HMO-2011-Choice Plus-LG-DC - redline.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter 11.9.16
Comments:	
Attachment(s):	Cover Letter 11.9.16.pdf

State: District of Columbia
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: 2017 UHIC Large Group Forms
Project Name/Number: /

Filing Company: UnitedHealthcare Insurance Company

Item Status:	
Status Date:	

UnitedHealthcare Insurance Company
NAIC #79413

CERTIFICATION OF COMPLIANCE/READABILITY

This is to certify that the accompanying forms comply with your state's readability requirements:

A. **Option Selected**
The forms are scored separately for the Flesch reading ease test. Scores are indicated below.

Form Name	Form Number	Flesch Score
Certificate of Coverage	COC17.CER.I.11.LG.DC	50.6
Choice Schedule of Benefits	SBN17.CHC.I.11.LG.DC	55.8
Choice Plus Schedule of Benefits	SBN17.CHP.I.11.LG.DC	56.0
Options Schedule of Benefits	SBN17.OPT.I.11.LG.DC	54.5
Non-Differential Schedule of Benefits	SBN17.NDF.I.11.LG.DC	53.3
Outpatient Prescription Drug Rider (Network)	RDR.RX.NET.17.I.11.LG.DC	52.9
Outpatient Prescription Drug Rider (Network/Non-Network)	RDR.RX.PLS.17.I.11.LG.DC	50.9
Outpatient Prescription Drug Schedule of Benefits (Network)	RDR.RXSBN.NET.17.I.11.LG.DC	57.5
Outpatient Prescription Drug Schedule of Benefits (Network/Non-Network)	RDR.RXSBN.PLS.17.I.11.LG.DC	59.2
Performance Rewards Amendment	POL.AMD.PR.I.11.DC	63.0
Catalyst Rider	CATL17.I.11.LG.DC	62.9

B. **Test Option Selected**
Test was applied to each entire policy form.

C. **Standards for Certification**
A checked block indicates the standard has been achieved.

X 1. The form text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option chosen in Section A above.

X 2. It is printed in not less than ten point type, one point leaded.

X 3. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders.

X 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text, if the policy has more than three thousand words printed on three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

X 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the forms.

Date: 11/9/16 Carmel Colica, Assistant Secretary

UnitedHealthcare Insurance Company

Statement of Variability
for
Outpatient Prescription Drug Schedule of Benefits
(Form No. RDR.RXSBN.NET.17.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Outpatient Prescription Drug Schedule of Benefits* and in the table below. These superscript numbers will be removed and will not appear in the *Outpatient Prescription Drug Rider* issued to the Enrolling Group.

The *Outpatient Prescription Drug Schedule of Benefits* contains various numerical ranges. These ranges will be used to indicate Copayments, Coinsurance and tiers. The variable provisions will allow for different Copayments and/or Coinsurance on each tier. These variable provisions will also allow for different Copayments and/or Coinsurance for growth hormone therapy, therapeutic classes, and preventive medications within each tier. The number of tiers, Copayments and/or Coinsurance used in the *Outpatient Prescription Drug Schedule of Benefits* will be determined by the plan design the Enrolling Group selects. The ranges indicate the lowest and highest values and allow any value in between the lowest and highest to be used depending on the plan design the Enrolling Group selects.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Outpatient Prescription Drug Schedule of Benefits* will be used.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
1	*Benefits for Prescription Drug Products*	[1]Include when the plan design has closed panel Benefits.
1	*If a Brand-name Drug Becomes Available as a Generic*	[1]Include when the plan design has open panel Benefits. [2]Include when the plan design contains the mandatory or restrictive generic program. [3]Include when the plan design has closed panel Benefits.
2-3	*[Notification] [Prior Authorization] Requirements*	[1]Include when the plan design requires notification. [2]Include when the plan design requires prior authorization. [3]Include when the plan design contains the mandatory or restrictive generic program. [4]Include when the plan design has a Therapeutic Class Charge. [5]Include when the plan design has a Therapeutically

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		Equivalent Charge.
3	*Step Therapy*	[1]Include when the plan design applies step therapy requirements.
3-4	*What You Must Pay*	[1]Include when the plan design has an Annual Drug Deductible and/or a Specialty Prescription Drug Product Annual Deductible. Include "and" if applicable. [2]Include when the plan design does not apply Prescription Drug Products on the List of Preventive Medications to the Annual Drug Deductible. [3]Include when the plan design does not apply Preventive Care Medications to the Annual Drug Deductible. Required for non-grandfathered plans under Federal PPACA. [4]Include when the plan design does not apply insulin or diabetic supplies to the Annual Drug Deductible. Include "or" if applicable. [5]Include when the plan design has an Annual Deductible that combines medical and prescription drug Benefits. [6]Include when the plan design does not apply Prescription Drug Products on the List of Preventive Medications to the Annual Deductible. [7]Include when the plan design does not apply Preventive Care Medications to the Annual Deductible. Required for non-grandfathered plans under Federal PPACA. [8]Include when the plan design does not apply insulin or diabetic supplies to the Annual Deductible. Include "or" if applicable. [9]Include when the plan design contains the mandatory or restrictive generic program (Ancillary Charge). Modify text as applicable. [10]Include when the plan design has a Therapeutic Class Charge. [11]Include when the plan design has a Therapeutically Equivalent Charge. [12]Include when the plan design contains the mandatory generic program. [13]Include based on plan design those items that are not applied to the Out-of-Pocket Maximum stated in the applicable *Certificate of Coverage*.
5	*Payment Information*	[1]Include when the plan design calculates Benefits on a calendar year basis. [2]Include when the plan design calculates benefits on a

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		Policy year basis. [3]Include the applicable provisions based on the plan design.
5-6	*Annual Drug Deductible*	[1]Include when the plan design has an Annual Drug Deductible. Include either Option 1 or Option 2 as shown in [2] and [3] below. [2]Include when the plan design uses Option 1. Option 1 applies when the Annual Drug Deductible is determined based on Network or Non-Network status. Modify text based on the plan design. [3]Include when the plan design uses Option 2. Option 2 applies when the Annual Drug Deductible is determined based on tier status. Modify text based on the plan design. [4]Include when the plan design does not apply Prescription Drug Products on the List of Preventive Medications to the Annual Drug Deductible. [5]Include when the plan design does not apply Preventive Care Medications to the Annual Drug Deductible. [6]Include when the plan design does not apply insulin and/or diabetic supplies to the Annual Drug Deductible. Include "or" if applicable. [7]Include when the plan design has an Annual Drug Deductible carry-over provision. Modify text to reflect whether Benefits are calculated on a calendar or Policy year basis. [8]Include when the plan design applies the carry-over provision to only the individual Annual Drug Deductible. [9]Include when the plan design applies an Annual Drug Deductible roll-over provision. [10]Include when the plan design applies the roll-over provision to the Annual Drug Deductible and the plan changes from a calendar to a Policy year plan. [11]Include when the plan design applies the roll-over provision to only the individual Annual Drug Deductible. [12]Include when the plan design may not permit certain coupons/offers from pharmaceutical manufacturers to apply to the Annual Drug Deductible. [13]These variable options are used with Option 1. Modify text based on the plan design. [14]Include when the plan design does not have an Annual Drug Deductible. [15]Include when the plan design has an individual Annual Drug Deductible.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		[16]Include when the plan design has an individual (with family maximum) Annual Drug Deductible. [17]These variable options are used with Option 2. Modify text based on the plan design.
6-8	*Specialty Prescription Drug Product Annual Deductible*	[1]Include when the plan design has a Specialty Prescription Drug Product Annual Deductible. Include either Option 1 or Option 2 as shown in [2] and [3] below. [2]Include when the plan design uses Option 1. Option 1 applies when the Specialty Prescription Drug Product Annual Deductible is based on either specialty drug product, per specialty drug product, per therapeutic class and/or growth hormone therapy. Modify text based on the plan design. [3]Include when the plan design uses Option 2. Option 2 applies when the Specialty Prescription Drug Product Annual Deductible is determined based on tier status. Modify text based on the plan design. [4]Include when the plan design has a Specialty Prescription Drug Product Annual Deductible carry-over provision. Modify text to reflect whether Benefits are calculated on a calendar or Policy year basis. [5]Include when the plan design applies the carry-over provision to only the individual Specialty Prescription Drug Product Annual Deductible. [6]Include when the plan design applies a Specialty Prescription Drug Product Annual Deductible roll-over provision. [7]Include when the plan design applies the roll-over provision to the Specialty Prescription Drug Product Annual Deductible and the plan changes from a calendar to a Policy year plan. [8]Include when the plan design applies the roll-over provision to only the individual Specialty Prescription Drug Product Annual Deductible. [9]Include when the plan design includes the Specialty Prescription Drug Product Annual Deductible in the overall Annual Drug Deductible. [10]Include when the plan design may not permit certain coupons/offers from pharmaceutical manufacturers to apply to the Specialty Drug Product Annual Deductible. [11]These variable options are used with Option 1. Modify text based on the plan design. [12]Include when the plan design has an individual Specialty Prescription Drug Product Annual Deductible. [13]Include when the plan design has an individual (with family maximum) Specialty Prescription Drug Product

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		Annual Deductible. [14]Include when the plan design not have a Specialty Prescription Drug Product Annual Deductible. Modify text to include applicable tiers. [15]These variable options are used with Option 2. Modify text based on the plan design.
8-10	*Out-of-Pocket Drug Maximum*	[1]Include when the plan design has an Out-of-Pocket Drug Maximum. [2]Include when the plan design applies the Out-of-Pocket Drug Maximum annually. Modify text as applicable. [3]Include when the plan design applies the Out-of-Pocket Drug Maximum monthly. Modify text as applicable. [4]Include when the plan design does not limit Copayments and/or Coinsurance for Specialty Drug Products by the Out-of-Pocket Drug Maximum. [5]Include when the plan design does not limit Copayments and/or Coinsurance for Specialty Drug Products for infertility by the Out-of-Pocket Drug Maximum. [6]Include when the plan design has an individual Out-of-Pocket Drug Maximum. [7]Include when the plan design has an individual (with family maximum) Out-of-Pocket Drug Maximum. [8]Include when the plan design does not apply the Copayments and Coinsurance to the Out-of-Pocket Drug Maximum. [9]Include when the plan design has an Annual Drug Deductible. Modify text to include or not include the Annual Drug Deductible in the Out-of-Pocket Drug Maximum.
10-11	*Specialty Prescription Drug Product Out-of-Pocket Maximum*	[1]Include when the plan design has a Specialty Prescription Drug Product Out-of-Pocket Maximum. [2]Include when the plan design applies the Specialty Prescription Drug Product Out-of-Pocket Maximum annually. Modify text as applicable. [3]Include when the plan design applies the Specialty Prescription Drug Product Out-of-Pocket Maximum monthly. Modify the text as applicable. [4]Include when the plan design does not limit Specialty Prescription Drug Products for infertility by the Specialty Prescription Drug Product Out-of-Pocket Maximum. [5]Include when the plan design has an individual Specialty Prescription Drug Pocket Out-of-Pocket Maximum.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		[6]Include when the plan design has an individual (with family maximum) Specialty Prescription Drug Product Out-of-Pocket Maximum. [7]Include when the plan design has a Specialty Prescription Drug Product Annual Deductible. Modify text to include or not include the Specialty Prescription Drug Product Annual Deductible in the Specialty Prescription Drug Product Out-of-Pocket Maximum. [8]Include when the plan design does not apply the Copayments and Coinsurance to the Specialty Prescription Drug Out-of-Pocket Drug Maximum.
11	*Infertility Annual Maximum Benefit*	[1]Include when the plan design has an Infertility Annual Maximum Benefit.
11-12	*Infertility Maximum Policy Benefit*	[1]Include when the plan design has an Infertility Maximum Policy Benefit.
12-14	*Copayment and Coinsurance*	[1]Include when the plan design applies regimen pricing to therapeutic treatments. [2]Include when the plan design contains the enhanced Benefits program. Modify text to include the applicable notification or prior authorization requirements. [3]Include when the plan design has the Copayment/Coinsurance Waiver Program. [4]Include applicable text. [5]Include when the plan design has a Prescription Drug Charge. [6]Include when the plan design contains the mail order pharmacy Benefit. [7]Include when the plan design does not require a Copayment and/or Coinsurance for Preventive Care Medications.
15-18	*Specialty Prescription Drug Products*	[1]Include when the plan design contains Benefits for Specialty Prescription Drug Products. [2]Modify text based on plan design. [3]Include smart fill program included based on plan design. [4]Include when the plan design has closed panel Benefits.
18-23	*Prescription Drugs from a Retail Network Pharmacy*	[1]Include when the plan design provides 90-day generic drug coverage. [2]Include when the plan design has Preferred and/or Non-Preferred Retail Pharmacy Benefits. Modify the text as applicable.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		[3]Include when the plan design has a Preferred Retail Network Pharmacy Benefit and Copayments or Coinsurance decrease when prescription drugs are obtained at the Preferred Retail Network Pharmacy. Modify text as applicable. [4]Include when the plan design has a Non-Preferred Retail Network Pharmacy Benefit and Copayments or Coinsurance increase when prescription drugs are obtained at a Non-Preferred Retail Network Pharmacy. Modify text as applicable. [5]Include when the plan design when the plan has closed panel Benefits.
23-30	*Prescription Drug Products from a Mail Order Network Pharmacy*	[1]Include when the plan design contains Benefits for prescription drugs obtained from a mail order Network Pharmacy. [2]Include when the plan design includes the specialty drug program. [3]Include when the plan design contains the List of Preventive Medications. [4]Include when the plan design has 1 times Copayment and/or Coinsurance from a mail order Network Pharmacy. [5]Include when based on the plan design requires coverage at a retail pharmacy prior to using mail order coverage. Modify text as applicable. [6]Include when the plan design applies an initially limited mail day supply. Modify text as applicable. [7]Include when based on the plan design applies Copayments and/or Coinsurance for full 90-day supply. [8]Include when the plan design has a Preferred Mail Order Network Pharmacy and/or Non-Preferred Mail Order Network Pharmacy Benefits. Modify text as applicable. [9]Include when the plan design has a Preferred Mail Order Network Pharmacy Benefit and Copayments or Coinsurance decrease when prescription drugs are obtained at the Preferred Mail Order Network Pharmacy. Modify text as applicable. [10]Include when the plan design has a Non-Preferred Mail Order Network Pharmacy Benefit and Copayments or Coinsurance increase when prescription drugs are obtained at the Non-Preferred Mail Order Network Pharmacy. Modify text as applicable. [11]Include when the plan design has closed panel Benefits.

UnitedHealthcare Insurance Company

Statement of Variability
for
Choice Plus Schedule of Benefits (Form No. SBN17.CHP.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

The numbers before each Benefit in the *Schedule of Benefits* are bracketed to allow these numbers to be changed based on the plan design selected by the Enrolling Group. The brackets will be removed from these numbers and the numbers will be consecutive in the *Schedule of Benefits* issued to the Subscribers and the Enrolling Group.

The page numbers at the bottom of the pages are bracketed to allow these numbers to be consecutive in the *Schedule of Benefits* that is issued to the Subscribers and the Enrolling Group.

Our Internet address of www.myuhc.com is bracketed to allow for changes in this Internet address.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Schedule of Benefits* and in the tables below. These superscript numbers will be removed and will not appear in the *Schedule of Benefits* issued to the Subscribers and the Enrolling Group.

The *Schedule of Benefits* contains various numerical ranges. These ranges will be used to indicate Copayments, Coinsurance, Benefit limits, percentages of Eligible Expenses and applicable reductions in Benefits or no Benefits in the prior authorization requirements. When tiers are included (for example, pharmaceutical products), the applicable Coinsurance and number of tiers will be included. The numbers used in each Schedule of Benefits will be determined by the plan design the Enrolling Group selects. The ranges indicate the lowest and highest values and allow any value in between the lowest and highest to be used depending on the plan design the Enrolling Group selects.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Schedule of Benefits* will be used.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
1-3	*Accessing Benefits*	[1]Include when the plan design has Designated Network Benefits in any Benefit category. Modify text as applicable. [2]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist or pathologist for services provided in a Network facility as Network Benefits. [3]Include when the plan pays Emergency Medical Services provided by a non-Network provider as Network

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		Benefits and the Covered Person is held harmless. [4]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist or pathologist for services provided in a Network facility as Network benefits and the Covered Person is held harmless. [5]Include when the plan design does not pay non-Network Physicians for non-emergent services at a Network facility as billed charges. [6]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultants at a Network facility as non-Network Benefits. [7]Include when the plan design has the enhanced benefits program.
3-5	*Covered Health Services which Require Prior Authorization*	Include applicable Covered Health Services requiring prior authorization. Modify text as applicable.
6	*Benefits*	[1]Include when the plan design calculates Benefits on a calendar year basis. [2]Include when the plan design calculates Benefits on a Policy year basis. [3]Include when the plan design provides Designated Network Benefits in any Benefit category.
7-9	*Payment Term and Description - Annual Deductible*	[1]Include when the plan design applies any combination of medical and prescription drug Benefits to the Annual Deductible. [2]Include when the plan design does not apply preventive medications to the Annual Deductible. [3]Include applicable option when the plan design does not apply insulin and/or diabetic supplies to the Annual Deductible. Modify text as applicable. [4]Include when the plan design has an Annual Deductible for Designated Network and Network Benefits and the Network and Non-Network amounts paid under the *Outpatient Prescription Drug Rider* apply to the Designated Network and Network Annual Deductible. [5]Include when the plan design has Designated Network Benefits in any Benefit category. [6]Include when the plan design applies day/visit limits to the Annual Deductible. [7]Include when the plan design applies a carry-over provision to the Annual Deductible. [8]Include when the plan design applies a roll-over provision to the Annual Deductible.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[9]Include when the plan design applies the roll-over provision to the Annual Deductible and the plan changes from a calendar to a Policy year plan. [10]Include when the plan design applies the roll-over provision to only the individual Annual Deductible. [11]Include when the plan design does not apply the Per Occurrence Copayment to the Annual Deductible. [12]Include separate or combined categories of Designated Network, Network and Non-Network based on the plan design. Modify text as applicable. [13]Include when the plan design has separate individual and family Annual Deductibles. [14]Include when the plan design has an individual Annual Deductible. [15]Include when the plan design has an individual (with family maximum) Annual Deductible. [16]Include when the plan design does not have an Annual Deductible. [17]Include when cross accumulation applies to Designated Network and Network Annual Deductible.
9	*Payment Term and Description - Per Occurrence Copayment*	Include when the plan design has a Per Occurrence Copayment.
9-14	*Payment Term and Description - Out-of-Pocket Maximum*	[1]Include when the plan design applies the Per Occurrence Copayment and/or Copayments to the Out-of-Pocket Maximum. Modify the text as applicable. [2]Include when the plan design applies any combination of medical and prescription drug Benefits to the Out-of-Pocket Maximum. [3]Include when the plan design has an Out-of-Pocket Maximum for Designated Network and Network Benefits and the Network and Non-Network amounts paid under the *Outpatient Prescription Drug Rider* apply to the Designated Network and Network Benefits Out-of-Pocket Maximum. [4]Include when the plan design has Designated Network Benefits in any Benefit category. [5]Include when the plan design applies prior authorization for any Benefit and does not support applying penalties to the Out-of-Pocket Maximum. [6]Include when the plan design does not apply Copayments and/or Coinsurance for prescription drug products to the Out-of-Pocket Maximum. [7]Include separate or combined categories of Designated Network, Network and Non-Network based on the plan

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		design. Modify text as applicable. [8]Include when the plan design has separate individual and family Out-of-Pocket Maximums. [9]Include when the plan design has an individual Out-of-Pocket Maximum. [10]Include when the plan design has an individual (with family maximum) Out-of-Pocket Maximum. [11]Include when the plan design applies the Annual Deductible to the Out-of-Pocket Maximum. [12]Include when the plan design applies the Per Occurrence Copayment to the Out-of-Pocket Maximum. [13]Include when the plan design does not apply the Per Occurrence Copayment to the Out-of-Pocket Maximum. [14]Include when the plan design does not have an Out-of-Pocket Maximum.
14	*Copayment*	Include when the plan design has tiered Copayments for Pharmaceutical Products.
14-15	*Coinsurance*	Include when the plan design has tiered Coinsurance for Pharmaceutical Products.
15-114	*Header for Schedule of Benefits*	Include Designed Network Benefits when the plan design has Designated Network Benefits in any Benefit category.
15-16	*Acupuncture Services*	Optional Benefit the Enrolling Group can select.
18-21	*Congenital Heart Disease Surgeries*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits only for inpatient facility charges under this Benefit. [3]Include when the plan design has Network and Non-Network Benefits only for inpatient facility charges for congenital heart disease surgery. [4]Include when the plan design requires use of a Designated Facility.
21-22	*Dental Services - Accident Only*	Optional benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable.
22-27	*Diabetes Services*	[1]Include when the plan design provides the *Durable Medical Equipment* Benefit. [2]Include when the plan design does not provide the *Durable Medical Equipment* Benefit.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[3]Include when the plan design provides the *Durable Medical Equipment* Benefit with limits. [4]Include when the plan design provides the *Durable Medical Equipment* Benefit and contains an *Outpatient Prescription Drug Rider*. [5]Include when the plan design provides the *Durable Medical Equipment* Benefit and does not contain an *Outpatient Prescription Drug Rider.* Modify text as applicable. [6]Include when the plan design contains an *Outpatient Prescription Drug Rider* but does not provide the *Durable Medical Equipment* Benefit. [7]Include when the plan design does not provide the *Durable Medical Equipment* Benefit or contain an *Outpatient Prescription Drug Rider.*
25-27	*Durable Medical Equipment*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design limits frequency of Durable Medical Equipment purchases. Modify text as applicable. [3]Include when the plan design limits coverage for Mobility Devices. Modify text as applicable. [4]Include when the plan design limits coverage for speech aid and tracheo-esophageal voice devices. Modify text as applicable. [5]Include when the plan design requires purchase or rental of Durable Medical Equipment from the vendor we identify or requires purchase from the prescribing Network Physician to receive Network Benefits.
27-28	*Emergency Medical Services - Outpatient*	[1]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section. Modify text as applicable. [2]Include when the plan design provides coverage for Manipulative Treatment.
28-29	*Hearing Aids*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design provides coverage for hearing aids for Covered Persons age 18 or older. Modify text as applicable. [2]Include when the plan design only provides coverage for Enrolled Dependent children under the age of 18.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
29-30	*Home Health Care*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2] Must include at least 40 visits per year for home health care.
30-31	*Hospice Care*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Plan design determined by Enrolling Group.
31-35	*Hospital - Inpatient Stay*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits. Modify text as applicable. [3]Include when the plan design requires ventricular assist device implantation to be received at a Designated Facility. [4]Include when the plan design has limits for Non-Network Benefit ventricular assist device implantation.
35-36	*Infertility Services*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a Benefit limit. [3]Include when the plan design has a maximum Benefit combined with infertility drugs under the *Outpatient Prescription Drug Rider*. [4]Include when the plan design has a Benefit limit for Assisted Reproductive Technology.
36-45	*Lab, X-Ray and Diagnostics - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
45-49	*Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
49-55	*Mental Health Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
55-60	*Neurobiological Disorder-Autism Spectrum Disorder Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
60-63	*Obesity Surgery*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a dollar Benefit limit.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		Modify text as applicable. [3]Include when the plan design has a Benefit limit. [4]Include when the plan design requires obesity surgery to be received in a Designated Facility to receive Network Benefits. [5]Include when plan design includes services provided at a Network facility that is not a Designated Facility as Non-Network Benefits.
62-63	*Ostomy Supplies*	Optional Benefit the Enrolling Group can select.
63-66	*Pharmaceutical Products - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
66-70	*Physician Fees for Surgical and Medical Services*	[1]Include when the plan design does not pay non-Network Physicians for non-emergent services at a Network facility as billed charges. [2]Include when the plan design applies enhanced benefits to specific Physician services. Include applicable specialties. [3]Include when the plan design pays non-Network providers for services in a Network facility as Network Benefits. Do not include if [1] above is used.
70-79	*Physician's Office Services - Sickness and Injury*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design applies enhanced benefits to specific Physician services. Include applicable specialties. [3]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section. Include applicable Benefit categories. [4]Include when the plan design provides separate Copayments for children. Modify text as applicable to include the Copayments from the variable options for each category.
79	*Pregnancy - Maternity Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design does not apply an Annual Deductible for a newborn child. [3]Include when the plan design has a Copayment for initial office visit.
79-81	*Preventive Care Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
81-82	*Prosthetic Devices*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a limit.
82-83	*Reconstruction Procedures*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design does not provide the *Prosthetic Devices* Benefit. Modify text as applicable.
83-85	*Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design covers Manipulative Treatment. [2]Include when the plan design requires prior authorization. Modify text as applicable. [3]Include applicable Copayment and/or Coinsurance when Copayment and/or Coinsurance apply to all services including Manipulative Treatment and physical and occupational therapies. The Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Physician under the *Physician's Office Services - Sickness and Injury* Benefit. [4]Include applicable Copayment and/or Coinsurance when there is a separate Copayment and/or Coinsurance for Manipulative Treatment and physical and occupational therapies. The Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Physician under the *Physician's Office Services - Sickness and Injury* Benefit.
85-89	*Scopic Procedures - Outpatient Diagnostic and Therapeutic*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
89-91	*Skilled Nursing Facility/Inpatient Rehabilitation Services*	Enrolling Group determines visit limits. [1]Include when the plan design requires prior authorization. Modify text as applicable.
91-96	*Substance Use*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
96-103	*Surgery – Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
103-104	*Temporomandibular and Craniomandibular Joint Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
104-105	*Therapeutic Treatments – Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
108	*Transplantation Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
108-109	*Urgent Care Center Services*	[1]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section.
111	*Virtual Visits*	
111-112	*Vision Examinations*	Optional Benefit the Enrolling Group can select. Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Care Physician under the *Physician Office Services - Sickness and Injury* Benefit when applicable.
112-113	*Wigs*	Enrolling Group can elect to purchase this benefit.
114-118	*Eligible Expenses*	[1]Include when the plan design has Designated Network Benefits. [2]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultant for services provided in a Network facility as Network Benefits at less than billed charges. [3]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultant for services provided in a Network facility as Network Benefits at less than billed charges and Covered Person is held harmless for Emergency Medical Services. [4]Include applicable option for determining Eligible Expenses for Non-Network Benefits based on the plan design and delete the other option. Modify text as applicable. [5]Include when non-Network Physicians at a Network facility are not paid at billed charges.
105	*Designated Facilities and Other Providers*	[1]Include when the plan design provides coverage for ventricular assist device implantation.

UnitedHealthcare Insurance Company

Statement of Variability
for
Choice Schedule of Benefits (Form No. SBN17.CHC.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

The numbers before each Benefit in the *Schedule of Benefits* are bracketed to allow these numbers to be changed based on the plan design selected by the Enrolling Group. The brackets will be removed from these numbers and the numbers will be consecutive in the *Schedule of Benefits* issued to the Subscribers and the Enrolling Group.

The page numbers at the bottom of the pages are bracketed to allow these numbers to be consecutive in the *Schedule of Benefits* that is issued to the Subscribers and the Enrolling Group.

Our Internet address of www.myuhc.com is bracketed to allow for changes in this Internet address.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Schedule of Benefits* and in the tables below. These superscript numbers will be removed and will not appear in the *Schedule of Benefits* issued to the Subscribers and the Enrolling Group.

The *Schedule of Benefits* contains various numerical ranges. These ranges will be used to indicate Copayments, Coinsurance, Benefit limits, percentages of Eligible Expenses and applicable reductions in Benefits or no Benefits in the prior authorization requirements. When tiers are included (for example, pharmaceutical products), the applicable Coinsurance and number of tiers will be included. The numbers used in each Schedule of Benefits will be determined by the plan design the Enrolling Group selects. The ranges indicate the lowest and highest values and allow any value in between the lowest and highest to be used depending on the plan design the Enrolling Group selects.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Schedule of Benefits* will be used.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
1-2	*Accessing Benefits*	[1]Include when the plan design has Designated Network Benefits in any Benefit category. Modify text as applicable. [2]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist or pathologist for services provided in a Network facility as Network Benefits. [3]Include when the plan pays Emergency Medical Services provided by a non-Network provider as Network

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		Benefits and the Covered Person is held harmless. [4]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist or pathologist for services provided in a Network facility as Network benefits and the Covered Person is held harmless. [5]Include when the plan design does not pay non-Network Physicians for non-emergent services at a Network facility as billed charges. [6]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultants at a Network facility as non-Network Benefits. [7]Include when the plan design has the enhanced benefits program.
2	*Covered Health Services which Require Prior Authorization*	Include applicable Covered Health Services requiring prior authorization. Modify text as applicable.
4	*Benefits*	[1]Include when the plan design calculates Benefits on a calendar year basis. [2]Include when the plan design calculates Benefits on a Policy year basis. [3]Include when the plan design provides Designated Network Benefits in any Benefit category.
4-5	*Payment Term and Description - Annual Deductible*	[1]Include when the plan design applies any combination of medical and prescription drug Benefits to the Annual Deductible. [2]Include when the plan design does not apply preventive medications to the Annual Deductible. [3]Include applicable option when the plan design does not apply insulin and/or diabetic supplies to the Annual Deductible. Modify text as applicable. [4]Include when the plan design has an Annual Deductible for Designated Network and Network Benefits and the Network and Non-Network amounts paid under the *Outpatient Prescription Drug Rider* apply to the Designated Network and Network Annual Deductible. [5]Include when the plan design has Designated Network Benefits in any Benefit category. [6]Include when the plan design applies day/visit limits to the Annual Deductible. [7]Include when the plan design applies a carry-over provision to the Annual Deductible. [8]Include when the plan design applies a roll-over provision to the Annual Deductible.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[9]Include when the plan design applies the roll-over provision to the Annual Deductible and the plan changes from a calendar to a Policy year plan. [10]Include when the plan design applies the roll-over provision to only the individual Annual Deductible. [11]Include when the plan design does not apply the Per Occurrence Copayment to the Annual Deductible. [12]Include separate or combined categories of Designated Network, Network and Non-Network based on the plan design. Modify text as applicable. [13]Include when the plan design has separate individual and family Annual Deductibles. [14]Include when the plan design has an individual Annual Deductible. [15]Include when the plan design has an individual (with family maximum) Annual Deductible. [16]Include when the plan design does not have an Annual Deductible.
5-6	*Payment Term and Description - Per Occurrence Copayment*	Include when the plan design has a Per Occurrence Copayment.
6-9	*Payment Term and Description - Out-of-Pocket Maximum*	[1]Include when the plan design applies the Per Occurrence Copayment and/or Copayments to the Out-of-Pocket Maximum. Modify the text as applicable. [2]Include when the plan design applies any combination of medical and prescription drug Benefits to the Out-of-Pocket Maximum. [3]Include when the plan design has an Out-of-Pocket Maximum for Designated Network and Network Benefits and the Network and Non-Network amounts paid under the *Outpatient Prescription Drug Rider* apply to the Designated Network and Network Benefits Out-of-Pocket Maximum. [4]Include when the plan design has Designated Network Benefits in any Benefit category. [5]Include when the plan design applies prior authorization for any Benefit and does not support applying penalties to the Out-of-Pocket Maximum. [6]Include when the plan design does not apply Copayments and/or Coinsurance for prescription drug products to the Out-of-Pocket Maximum. [7]Include separate or combined categories of Designated Network, Network and Non-Network based on the plan design. Modify text as applicable. [8]Include when the plan design has separate individual

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		and family Out-of-Pocket Maximums. [9]Include when the plan design has an individual Out-of-Pocket Maximum. [10]Include when the plan design has an individual (with family maximum) Out-of-Pocket Maximum. [11]Include when the plan design applies the Annual Deductible to the Out-of-Pocket Maximum. [12]Include when the plan design applies the Per Occurrence Copayment to the Out-of-Pocket Maximum. [13]Include when the plan design does not apply the Per Occurrence Copayment to the Out-of-Pocket Maximum. [14]Include when the plan design does not have an Out-of-Pocket Maximum.
9-10	*Copayment*	Include when the plan design has tiered Copayments for Pharmaceutical Products.
10	*Coinsurance*	Include when the plan design has tiered Coinsurance for Pharmaceutical Products.
10-71	*Header for Schedule of Benefits*	Include Designed Network Benefits when the plan design has Designated Network Benefits in any Benefit category.
10	*Acupuncture Services*	Optional Benefit the Enrolling Group can select.
12-13	*Congenital Heart Disease Surgeries*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits only for inpatient facility charges under this Benefit. [3]Include when the plan design has Network and Non-Network Benefits only for inpatient facility charges for congenital heart disease surgery. [4]Include when the plan design requires use of a Designated Facility.
13-14	*Dental Services - Accident Only*	Optional benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable.
13-16	*Diabetes Services*	[1]Include when the plan design provides the *Durable Medical Equipment* Benefit. [2]Include when the plan design does not provide the *Durable Medical Equipment* Benefit. [3]Include when the plan design provides the *Durable Medical Equipment* Benefit with limits.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[4]Include when the plan design provides the *Durable Medical Equipment* Benefit and contains an *Outpatient Prescription Drug Rider*. [5]Include when the plan design provides the *Durable Medical Equipment* Benefit and does not contain an *Outpatient Prescription Drug Rider.* Modify text as applicable. [6]Include when the plan design contains an *Outpatient Prescription Drug Rider* but does not provide the *Durable Medical Equipment* Benefit. [7]Include when the plan design does not provide the *Durable Medical Equipment* Benefit or contain an *Outpatient Prescription Drug Rider.*
16-17	*Durable Medical Equipment*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design limits frequency of Durable Medical Equipment purchases. Modify text as applicable. [3]Include when the plan design limits coverage for Mobility Devices. Modify text as applicable. [4]Include when the plan design limits coverage for speech aid and tracheo-esophageal voice devices. Modify text as applicable. [5]Include when the plan design requires purchase or rental of Durable Medical Equipment from the vendor we identify or requires purchase from the prescribing Network Physician to receive Network Benefits.
17-18	*Emergency Medical Services - Outpatient*	[1]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section. Modify text as applicable. [2]Include when the plan design provides coverage for Manipulative Treatment.
18-19	*Hearing Aids*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design provides coverage for hearing aids for Covered Persons age 18 or older. Modify text as applicable. [2]Include when the plan design only provides coverage for Enrolled Dependent children under the age of 18.
19	*Home Health Care*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2] Must include at least 40 visits per year for home health

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		care.
19-20	*Hospice Care*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Plan design determined by Enrolling Group.
20-22	*Hospital - Inpatient Stay*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits. Modify text as applicable. [3]Include when the plan design requires ventricular assist device implantation to be received at a Designated Facility. [4]Include when the plan design has limits for Non-Network Benefit ventricular assist device implantation.
22-23	*Infertility Services*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a Benefit limit. [3]Include when the plan design has a maximum Benefit combined with infertility drugs under the *Outpatient Prescription Drug Rider*. [4]Include when the plan design has a Benefit limit for Assisted Reproductive Technology.
23-29	*Lab, X-Ray and Diagnostics - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
29-31	*Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
31-35	*Mental Health Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
35-38	*Neurobiological Disorder-Autism Spectrum Disorder Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
38-39	*Obesity Surgery*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a dollar Benefit limit. Modify text as applicable. [3]Include when the plan design has a Benefit limit. [4]Include when the plan design requires obesity surgery

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		to be received in a Designated Facility to receive Network Benefits. [5]Include when plan design includes services provided at a Network facility that is not a Designated Facility as Non-Network Benefits.
39	*Ostomy Supplies*	Optional Benefit the Enrolling Group can select.
39-41	*Pharmaceutical Products - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
41-44	*Physician Fees for Surgical and Medical Services*	[1]Include when the plan design does not pay non-Network Physicians for non-emergent services at a Network facility as billed charges. [2]Include when the plan design applies enhanced benefits to specific Physician services. Include applicable specialties. [3]Include when the plan design pays non-Network providers for services in a Network facility as Network Benefits. Do not include if [1] above is used.
44-50	*Physician's Office Services - Sickness and Injury*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design applies enhanced benefits to specific Physician services. Include applicable specialties. [3]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section. Include applicable Benefit categories. [4]Include when the plan design provides separate Copayments for children. Modify text as applicable to include the Copayments from the variable options for each category.
51	*Pregnancy - Maternity Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design does not apply an Annual Deductible for a newborn child. [3]Include when the plan design has a Copayment for initial office visit.
51	*Preventive Care Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
51-52	*Prosthetic Devices*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[2]Include when the plan design has a limit.
52	*Reconstruction Procedures*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design does not provide the *Prosthetic Devices* Benefit. Modify text as applicable.
52-54	*Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design covers Manipulative Treatment. [2]Include when the plan design requires prior authorization. Modify text as applicable. [3]Include applicable Copayment and/or Coinsurance when Copayment and/or Coinsurance apply to all services including Manipulative Treatment and physical and occupational therapies. The Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Physician under the *Physician's Office Services - Sickness and Injury* Benefit. [4]Include applicable Copayment and/or Coinsurance when there is a separate Copayment and/or Coinsurance for Manipulative Treatment and physical and occupational therapies. The Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Physician under the *Physician's Office Services - Sickness and Injury* Benefit.
54-56	*Scopic Procedures - Outpatient Diagnostic and Therapeutic*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
56-57	*Skilled Nursing Facility/Inpatient Rehabilitation Services*	Enrolling Group determines visit limits. [1]Include when the plan design requires prior authorization. Modify text as applicable.
57-61	*Substance Use*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
61-65	*Surgery – Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits.
65	*Temporomandibular and Craniomandibular Joint Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
65-68	*Therapeutic Treatments – Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
68	*Transplantation Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
68-70	*Urgent Care Center Services*	[1]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section.
70	*Virtual Visits*	Optional Benefit the Enrolling Group can select. Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Care Physician under the *Physician Office Services - Sickness and Injury* Benefit when applicable.
70	*Vision Examinations*	Optional Benefit the Enrolling Group can select. Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Care Physician under the *Physician Office Services - Sickness and Injury* Benefit when applicable.
71	*Wigs*	Enrolling Group can elect to purchase this benefit.
72-73	*Eligible Expenses*	[1]Include when the plan design has Designated Network Benefits. [2]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultant for services provided in a Network facility as Network Benefits at less than billed charges. [3]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultant for services provided in a Network facility as Network Benefits at less than billed charges and Covered Person is held harmless for Emergency Medical Services. [4]Include applicable option for determining Eligible Expenses for Non-Network Benefits based on the plan design and delete the other option. Modify text as applicable. [5]Include when non-Network Physicians at a Network facility are not paid at billed charges.
74	*Designated Facilities and Other Providers*	[1]Include when the plan design provides coverage for ventricular assist device implantation.

UnitedHealthcare Insurance Company

Statement of Variability
for
Non-Differential PPO Schedule of Benefits (Form No. SBN17.NDF.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

The numbers before each Benefit in the *Schedule of Benefits* are bracketed to allow these numbers to be changed based on the plan design selected by the Enrolling Group. The brackets will be removed from these numbers and the numbers will be consecutive in the *Schedule of Benefits* issued to the Subscribers and the Enrolling Group.

The page numbers at the bottom of the pages are bracketed to allow these numbers to be consecutive in the *Schedule of Benefits* that is issued to the Subscribers and the Enrolling Group.

Throughout the *Certificate of Coverage*, the Internet address variable, "www.myuhc.com", is bracketed to allow for changes in the Internet address.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Schedule of Benefits* and in the tables below. These superscript numbers will be removed and will not appear in the *Schedule of Benefits* issued to the Subscribers and the Enrolling Group.

The *Schedule of Benefits* contains various numerical ranges. These ranges will be used to indicate Copayments, Coinsurance, Benefit limits, percentages of Eligible Expenses and applicable reductions in Benefits or no Benefits in the pre-service notifications. When tiers are included (for example, pharmaceutical products), the applicable Coinsurance and number of tiers will be included. The numbers used in each Schedule of Benefits will be determined by the plan design the Enrolling Group selects. The ranges indicate the lowest and highest values and allow any value in between the lowest and highest to be used depending on the plan design the Enrolling Group selects.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Schedule of Benefits* will be used.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
1	*Accessing Benefits*	[1]Include when the plan design provides the Shared Savings Program.
2-3	*Covered Health Services which Require Prior Authorization*	Include applicable Covered Health Services requiring prior authorization. Modify text as applicable.
4	*Benefits*	[1]Include when the plan calculates Benefits on a calendar year basis.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[2]Include when the plan design calculates Benefits on a Policy year basis.
5-6	*Payment Term and Description - Annual Deductible*	[1]Include when the plan design applies any combination of medical and prescription drug Benefits to the Annual Deductible. [2]Include when the plan design does not apply preventive medications to the Annual Deductible. [3]Include applicable option when the plan design does not apply insulin and/or diabetic supplies to the Annual Deductible. Modify text as applicable. [4]Include when the plan design applies day/visit limits to the Annual Deductible. [5]Include when the plan design applies a carry-over provision to the Annual Deductible. [6]Include when the plan design applies a roll-over provision to the Annual Deductible. [7]Include when the plan design applies the roll-over provision to the Annual Deductible and the plan changes from a calendar to a Policy year plan. [8]Include when the plan design applies the roll-over provision to only the individual Annual Deductible. [9]Include when the plan design does not apply the Per Occurrence Copayment to the Annual Deductible. [10]Include when the plan design has separate individual and family Annual Deductibles. [11]Include when the plan design has an individual Annual Deductible. [12]Include when the plan design has an individual (with family maximum) Annual Deductible. [13]Include when the plan design does not have an Annual Deductible.
6	*Payment Term and Description - Per Occurrence Copayment*	Include when the plan design has a Per Occurrence Copayment.
6-7	*Payment Term and Description - Out-of-Pocket Maximum*	[1]Include when the plan design applies the Per Occurrence Copayment and/or Copayments to the Out-of-Pocket Maximum. [2]Include when the plan design applies any combination of medical and prescription drug Benefits to the Out-of-Pocket Maximum. [3]Include when the plan design applies prior authorization for any Benefit and does not support applying penalties to the Out-of-Pocket Maximum.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[4]Include when the plan design does not apply Copayments and/or Coinsurance for prescription drug products to the Out-of-Pocket Maximum. [5]Include when the plan design has separate individual and family Out-of-Pocket Maximums. [6]Include when the plan design has an individual Out-of-Pocket Maximum. [7]Include when the plan design has an individual (with family maximum) Out-of-Pocket Maximum. [8]Include when the plan design applies the Annual Deductible to the Out-of-Pocket Maximum. [9]Include when the plan design does not apply the Annual Deductible to the Out-of-Pocket Maximum. [10]Include when the plan design applies the Per Occurrence Copayment to the Out-of-Pocket Maximum. [11]Include when the plan design does not apply the Per Occurrence Copayment to the Out-of-Pocket Maximum. [12]Include when the plan design does not have an Out-of-Pocket Maximum.
7-8	*Copayment*	Include when the plan design has tiered Copayments for Pharmaceutical Products.
8	*Coinsurance*	Include when the plan design has tiered Coinsurance for Pharmaceutical Products.
8	*Acupuncture Services*	Optional Benefit the Enrolling Group can select.
9-10	*Congenital Heart Disease Surgeries*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
10	*Dental Services - Accident Only*	Optional benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable.
10-11	*Diabetes Services*	[1]Include when the plan design the Enrolling Group selects provides the *Durable Medical Equipment* Benefit. [2]Include when the plan design does not provide the *Durable Medical Equipment* Benefit. [3]Include when the plan design provides the *Durable Medical Equipment* Benefit with limits. [4]Include when the plan design provides the *Durable Medical Equipment* Benefit and contains an *Outpatient Prescription Drug Rider*. [5]Include when the plan design provides the *Durable Medical Equipment* Benefit and does not contain an *Outpatient Prescription Drug Rider.* Modify text as

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		applicable. [6]Include when the plan design contains an *Outpatient Prescription Drug Rider* but does not provide the *Durable Medical Equipment* Benefit. Modify text as applicable. [7]Include when the plan design does not provide the *Durable Medical Equipment* Benefit or contain an *Outpatient Prescription Drug Rider.* Modify text as applicable.
11-12	*Durable Medical Equipment*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include either when the plan design limits frequency of Durable Medical Equipment purchases. Modify text as applicable. [3]Include when the plan design limits coverage for Mobility Devices. Modify text as applicable. [4]Include when the plan limits coverage for speech aid and tracheo-esophageal voice devices. Modify text as applicable.
12-13	*Hearing Aids*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include limits selected by the Enrolling Group.
13	*Home Health Care*	[1]Include when the plan design the Enrolling Group selects requires prior authorization. Modify text as applicable. [2]Include limits selected by the Enrolling Group.
13	*Hospice Care*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include limits selected by Enrolling Group.
13-14	*Hospital - Inpatient Stay*	[1]Include when the plan design requires a reduction in Benefits when prior authorization is not obtained and/or pre-admission notification. Modify text as applicable.
14	*Infertility Services*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a Benefit limit. [3]Include when the plan design has a maximum benefit combined with infertility drugs under the *Outpatient Prescription Drug Rider*. [4]Include when the plan design has a Benefit limit for Assisted Reproductive Technology.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
14-15	*Lab, X-Ray and Diagnostics - Outpatient*	[1]Include when the plan design requires prior authorization for sleep studies. Modify text as applicable.
15-16	*Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
18-19	*Obesity Surgery*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a dollar Benefit limit. Modify text as applicable. [3]Include when the plan design has a Benefit limit.
19	*Ostomy Supplies*	Optional Benefit the Enrolling Group can select.
19-20	*Pharmaceutical Products - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
20-23	*Physician's Office Services - Sickness and Injury*	[1]Include when the plan design requires prior authorization for genetic testing. Modify text as applicable. [2]Include when the plan design provides separate Copayments for children. Modify text as applicable to include the Copayments from the variable options for each category.
23	*Pregnancy - Maternity Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design does not apply an Annual Deductible for a newborn child. [3]Include when the plan design has a Copayment for initial office visit.
23-24	*Preventive Care Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
24	*Prosthetic Devices*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a frequency limit.
24	*Reconstruction Procedures*	[1]Include when the plan design requires a reduction in Benefits when prior authorization is not obtained and/or pre-admission notification. Modify text as applicable. [2]Include when the plan design does not provide the *Prosthetic Devices* Benefit. Modify text as applicable.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
25-26	*Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]*	Optional Benefit the Enrolling Group can select. [1]Include when the plan covers Manipulative Treatment. [2]Include when the plan the design requires prior authorization. Modify text as applicable. [3]Include applicable Copayment and/or Coinsurance when Copayment and/or Coinsurance apply to all services including Manipulative Treatment and physical and occupational therapies. The Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Care Physician under the *Physician's Office Services - Sickness and Injury* Benefit. [4]Include applicable Copayment and/or Coinsurance when there is a separate Copayment and/or Coinsurance for Manipulative Treatment and physical and occupational therapies. The Copayment and/or Coinsurance for Manipulative Treatment must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Care Physician under the *Physician's Office Services - Sickness and Injury* Benefit.
26	*Scopic Procedures - Outpatient Diagnostic and Therapeutic*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
26-27	*Skilled Nursing Facility/Inpatient Rehabilitation Facility Services*	[1]Include when the plan design requires a reduction in Benefits when prior authorization is not obtained and/or pre-admission notification. Modify text as applicable.
31-32	*Surgery - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
29	*Temporomandibular and Craniomandibular Joint Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
29-30	*Therapeutic Treatments - Outpatient*	[1]Include when the plan requires prior authorization. Modify text as applicable.
30	*Transplantation Services*	[1]Include when the plan requires a reduction in Benefits when prior authorization is not obtained and/or pre-admission notification. Modify text as applicable.
31	*Virtual Visits*	Optional Benefit the Enrolling Group can select. Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Care Physician under the *Physician Office Services - Sickness and Injury* Benefit. If Copayment applied, the max cost share is $25 when

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		applicable.
31	*Vision Examinations*	Optional Benefit the Enrolling Group can select.
31	*Wigs*	Optional Benefit the Enrolling Group can select..
32-34	*Eligible Expenses*	[1]Include applicable option for determining Eligible Expenses for Non-Network Benefits based on the plan design and delete the other option. Modify text as applicable.

UnitedHealthcare Insurance Company

Statement of Variability
for
Options Schedule of Benefits (Form No. SBN17.OPT.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

The numbers before each Benefit in the *Schedule of Benefits* are bracketed to allow these numbers to be changed based on the plan design selected by the Enrolling Group. The brackets will be removed from these numbers and the numbers will be consecutive in the *Schedule of Benefits* issued to the Subscribers and the Enrolling Group.

The page numbers at the bottom of the pages are bracketed to allow these numbers to be consecutive in the *Schedule of Benefits* that is issued to the Subscribers and the Enrolling Group.

Our Internet address of www.myuhc.com is bracketed to allow for changes in this Internet address.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Schedule of Benefits* and in the tables below. These superscript numbers will be removed and will not appear in the *Schedule of Benefits* issued to the Subscribers and the Enrolling Group.

The *Schedule of Benefits* contains various numerical ranges. These ranges will be used to indicate Copayments, Coinsurance, Benefit limits, percentages of Eligible Expenses and applicable reductions in Benefits or no Benefits in the prior authorization requirements. When tiers are included (for example, pharmaceutical products), the applicable Coinsurance and number of tiers will be included. The numbers used in each Schedule of Benefits will be determined by the plan design the Enrolling Group selects. The ranges indicate the lowest and highest values and allow any value in between the lowest and highest to be used depending on the plan design the Enrolling Group selects.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Schedule of Benefits* will be used.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
1-3	*Accessing Benefits*	[1]Include when the plan design has Designated Network Benefits in any Benefit category. Modify text as applicable. [2]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist or pathologist for services provided in a Network facility as Network Benefits. [3]Include when the plan pays Emergency Medical Services provided by a non-Network provider as Network

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		Benefits and the Covered Person is held harmless. [4]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist or pathologist for services provided in a Network facility as Network benefits and the Covered Person is held harmless. [5]Include when the plan design does not pay non-Network Physicians for non-emergent services at a Network facility as billed charges. [6]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultants at a Network facility as non-Network Benefits. [7]Include when the plan design has the enhanced benefits program.
3-5	*Covered Health Services which Require Prior Authorization*	Include applicable Covered Health Services requiring prior authorization. Modify text as applicable.
6	*Benefits*	[1]Include when the plan design calculates Benefits on a calendar year basis. [2]Include when the plan design calculates Benefits on a Policy year basis. [3]Include when the plan design provides Designated Network Benefits in any Benefit category.
7-9	*Payment Term and Description - Annual Deductible*	[1]Include when the plan design applies any combination of medical and prescription drug Benefits to the Annual Deductible. [2]Include when the plan design does not apply preventive medications to the Annual Deductible. [3]Include applicable option when the plan design does not apply insulin and/or diabetic supplies to the Annual Deductible. Modify text as applicable. [4]Include when the plan design has an Annual Deductible for Designated Network and Network Benefits and the Network and Non-Network amounts paid under the *Outpatient Prescription Drug Rider* apply to the Designated Network and Network Annual Deductible. [5]Include when the plan design has Designated Network Benefits in any Benefit category. [6]Include when the plan design applies day/visit limits to the Annual Deductible. [7]Include when the plan design applies a carry-over provision to the Annual Deductible. [8]Include when the plan design applies a roll-over provision to the Annual Deductible.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[9]Include when the plan design applies the roll-over provision to the Annual Deductible and the plan changes from a calendar to a Policy year plan. [10]Include when the plan design applies the roll-over provision to only the individual Annual Deductible. [11]Include when the plan design does not apply the Per Occurrence Copayment to the Annual Deductible. [12]Include separate or combined categories of Designated Network, Network and Non-Network based on the plan design. Modify text as applicable. [13]Include when the plan design has separate individual and family Annual Deductibles. [14]Include when the plan design has an individual Annual Deductible. [15]Include when the plan design has an individual (with family maximum) Annual Deductible. [16]Include when the plan design does not have an Annual Deductible. [17]Include when cross accumulation applies to Designated Network and Network Annual Deductible.
9	*Payment Term and Description - Per Occurrence Copayment*	Include when the plan design has a Per Occurrence Copayment.
9-14	*Payment Term and Description - Out-of-Pocket Maximum*	[1]Include when the plan design applies the Per Occurrence Copayment and/or Copayments to the Out-of-Pocket Maximum. Modify the text as applicable. [2]Include when the plan design applies any combination of medical and prescription drug Benefits to the Out-of-Pocket Maximum. [3]Include when the plan design has an Out-of-Pocket Maximum for Designated Network and Network Benefits and the Network and Non-Network amounts paid under the *Outpatient Prescription Drug Rider* apply to the Designated Network and Network Benefits Out-of-Pocket Maximum. [4]Include when the plan design has Designated Network Benefits in any Benefit category. [5]Include when the plan design applies prior authorization for any Benefit and does not support applying penalties to the Out-of-Pocket Maximum. [6]Include when the plan design does not apply Copayments and/or Coinsurance for prescription drug products to the Out-of-Pocket Maximum. [7]Include separate or combined categories of Designated Network, Network and Non-Network based on the plan

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		design. Modify text as applicable. [8]Include when the plan design has separate individual and family Out-of-Pocket Maximums. [9]Include when the plan design has an individual Out-of-Pocket Maximum. [10]Include when the plan design has an individual (with family maximum) Out-of-Pocket Maximum. [11]Include when the plan design applies the Annual Deductible to the Out-of-Pocket Maximum. [12]Include when the plan design applies the Per Occurrence Copayment to the Out-of-Pocket Maximum. [13]Include when the plan design does not apply the Per Occurrence Copayment to the Out-of-Pocket Maximum. [14]Include when the plan design does not have an Out-of-Pocket Maximum.
14	*Copayment*	Include when the plan design has tiered Copayments for Pharmaceutical Products.
14-15	*Coinsurance*	Include when the plan design has tiered Coinsurance for Pharmaceutical Products.
15-114	*Header for Schedule of Benefits*	Include Designed Network Benefits when the plan design has Designated Network Benefits in any Benefit category.
15-16	*Acupuncture Services*	Optional Benefit the Enrolling Group can select.
18-21	*Congenital Heart Disease Surgeries*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits only for inpatient facility charges under this Benefit. [3]Include when the plan design has Network and Non-Network Benefits only for inpatient facility charges for congenital heart disease surgery. [4]Include when the plan design requires use of a Designated Facility.
21-22	*Dental Services - Accident Only*	Optional benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable.
22-27	*Diabetes Services*	[1]Include when the plan design provides the *Durable Medical Equipment* Benefit. [2]Include when the plan design does not provide the *Durable Medical Equipment* Benefit.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		[3]Include when the plan design provides the *Durable Medical Equipment* Benefit with limits. [4]Include when the plan design provides the *Durable Medical Equipment* Benefit and contains an *Outpatient Prescription Drug Rider*. [5]Include when the plan design provides the *Durable Medical Equipment* Benefit and does not contain an *Outpatient Prescription Drug Rider.* Modify text as applicable. [6]Include when the plan design contains an *Outpatient Prescription Drug Rider* but does not provide the *Durable Medical Equipment* Benefit. [7]Include when the plan design does not provide the *Durable Medical Equipment* Benefit or contain an *Outpatient Prescription Drug Rider.*
25-27	*Durable Medical Equipment*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design limits frequency of Durable Medical Equipment purchases. Modify text as applicable. [3]Include when the plan design limits coverage for Mobility Devices. Modify text as applicable. [4]Include when the plan design limits coverage for speech aid and tracheo-esophageal voice devices. Modify text as applicable. [5]Include when the plan design requires purchase or rental of Durable Medical Equipment from the vendor we identify or requires purchase from the prescribing Network Physician to receive Network Benefits.
27-28	*Emergency Medical Services - Outpatient*	[1]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section. Modify text as applicable. [2]Include when the plan design provides coverage for Manipulative Treatment.
28-29	*Hearing Aids*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design provides coverage for hearing aids for Covered Persons age 18 or older. Modify text as applicable. [2]Include when the plan design only provides coverage for Enrolled Dependent children under the age of 18.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
29-30	*Home Health Care*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2] Must include at least 40 visits per year for home health care.
30-31	*Hospice Care*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Plan design determined by Enrolling Group.
31-35	*Hospital - Inpatient Stay*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits. Modify text as applicable. [3]Include when the plan design requires ventricular assist device implantation to be received at a Designated Facility. [4]Include when the plan design has limits for Non-Network Benefit ventricular assist device implantation.
35-36	*Infertility Services*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a Benefit limit. [3]Include when the plan design has a maximum Benefit combined with infertility drugs under the *Outpatient Prescription Drug Rider*. [4]Include when the plan design has a Benefit limit for Assisted Reproductive Technology.
36-45	*Lab, X-Ray and Diagnostics - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
45-49	*Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
49-55	*Mental Health Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
55-60	*Neurobiological Disorder-Autism Spectrum Disorder Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
60-63	*Obesity Surgery*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a dollar Benefit limit.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		Modify text as applicable. [3]Include when the plan design has a Benefit limit. [4]Include when the plan design requires obesity surgery to be received in a Designated Facility to receive Network Benefits. [5]Include when plan design includes services provided at a Network facility that is not a Designated Facility as Non-Network Benefits.
62-63	*Ostomy Supplies*	Optional Benefit the Enrolling Group can select.
63-66	*Pharmaceutical Products - Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
66-70	*Physician Fees for Surgical and Medical Services*	[1]Include when the plan design does not pay non-Network Physicians for non-emergent services at a Network facility as billed charges. [2]Include when the plan design applies enhanced benefits to specific Physician services. Include applicable specialties. [3]Include when the plan design pays non-Network providers for services in a Network facility as Network Benefits. Do not include if [1] above is used.
70-79	*Physician's Office Services - Sickness and Injury*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design applies enhanced benefits to specific Physician services. Include applicable specialties. [3]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section. Include applicable Benefit categories. [4]Include when the plan design provides separate Copayments for children. Modify text as applicable to include the Copayments from the variable options for each category.
79	*Pregnancy - Maternity Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design does not apply an Annual Deductible for a newborn child. [3]Include when the plan design has a Copayment for initial office visit.
79-81	*Preventive Care Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
81-82	*Prosthetic Devices*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has a limit.
82-83	*Reconstruction Procedures*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design does not provide the *Prosthetic Devices* Benefit. Modify text as applicable.
83-85	*Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design covers Manipulative Treatment. [2]Include when the plan design requires prior authorization. Modify text as applicable. [3]Include applicable Copayment and/or Coinsurance when Copayment and/or Coinsurance apply to all services including Manipulative Treatment and physical and occupational therapies. The Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Physician under the *Physician's Office Services - Sickness and Injury* Benefit. [4]Include applicable Copayment and/or Coinsurance when there is a separate Copayment and/or Coinsurance for Manipulative Treatment and physical and occupational therapies. The Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Physician under the *Physician's Office Services - Sickness and Injury* Benefit.
85-89	*Scopic Procedures - Outpatient Diagnostic and Therapeutic*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
89-91	*Skilled Nursing Facility/Inpatient Rehabilitation Services*	Enrolling Group determines visit limits. [1]Include when the plan design requires prior authorization. Modify text as applicable.
91-96	*Substance Use*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
96-103	*Surgery – Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable. [2]Include when the plan design has Designated Network Benefits.

SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
103-104	*Temporomandibular and Craniomandibular Joint Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
104-105	*Therapeutic Treatments – Outpatient*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
108	*Transplantation Services*	[1]Include when the plan design requires prior authorization. Modify text as applicable.
108-109	*Urgent Care Center Services*	[1]Include when the plan design requires Copayments/Coinsurance stated under other Benefit categories in addition to the Copayment in this section.
111	*Virtual Visits*	
111-112	*Vision Examinations*	Optional Benefit the Enrolling Group can select. Copayment and/or Coinsurance must be the same as the *Physician's Office Services - Sickness and Injury* Benefit or a Primary Care Physician under the *Physician Office Services - Sickness and Injury* Benefit when applicable.
112-113	*Wigs*	Enrolling Group can elect to purchase this benefit.
114-118	*Eligible Expenses*	[1]Include when the plan design has Designated Network Benefits. [2]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultant for services provided in a Network facility as Network Benefits at less than billed charges. [3]Include when the plan design pays a non-Network Physician, radiologist, anesthesiologist, pathologist or consultant for services provided in a Network facility as Network Benefits at less than billed charges and Covered Person is held harmless for Emergency Medical Services. [4]Include applicable option for determining Eligible Expenses for Non-Network Benefits based on the plan design and delete the other option. Modify text as applicable. [5]Include when non-Network Physicians at a Network facility are not paid at billed charges.
105	*Designated Facilities and Other Providers*	[1]Include when the plan design provides coverage for ventricular assist device implantation.

UnitedHealthcare Insurance Company

Statement of Variability
for
Certificate of Coverage (Form No. COC17.CER.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

The numbers in the text (i.e., numbers before each Benefit in *Section 1: Covered Health Services* and the numbers before the exclusions in *Section 2: Exclusions and Limitations*) of the *Certificate of Coverage* are bracketed to allow these numbers to be changed based on the plan design selected by the Enrolling Group. The brackets will be removed from these numbers and the numbers will be consecutive in the *Certificate of Coverage* issued to the Subscribers and the Enrolling Group.

The page numbers in the *Table of Contents* and at the bottom of the pages are bracketed to allow these numbers to be consecutive in the *Certificate of Coverage* that is issued to the Subscribers and the Enrolling Group.

Our Internet address of www.myuhc.com is bracketed to allow for changes in this Internet address.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Certificate of Coverage* and in the tables below. These superscript numbers will be removed and will not appear in the *Certificate of Coverage* issued to the Subscribers and the Enrolling Group.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Certificate of Coverage* will be used.

CERTIFICATE OF COVERAGE - INTRODUCTION PAGES		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
1	*Certificate of Coverage is Part of Policy*	[1]Include this statement when any of the four Riders are included as part of the medical plan. [2]Include the Riders that are issued as part of the medical plan. Modify text as applicable.
3	*Obtain Prior Authorization*	[1]Include when the plan design has both Network and Non-Network Benefits and Network providers are responsible for obtaining prior authorization. [2]Include when the product is Options PPO and Network providers are not responsible for prior authorization or when the product is Non-Differential PPO and requires prior authorization for any service.

CERTIFICATE OF COVERAGE - SECTION 1: COVERED HEALTH SERVICES

PAGE NUMBER(S)	SUBSECTION TITLE	VARIABLE USE
8	*Benefits for Covered Health Services*	Include when the plan design has a Per Occurrence Copayment.
8	*Acupuncture Services*	Optional Benefit the Enrolling Group can select.
9-11	*Clinical Trials*	Include selected options when the plan design expands clinical trial coverage. Modify text as applicable.
11	*Congenital Heart Disease Surgeries*	Optional Benefit the Enrolling Group can select.
11	*Dental Services - Accident Only*	Optional Benefit the Enrolling Group can select.
12	*Diabetes Services*	**Personalized Support - Diabetes Program:** [1]Include Network reference when issued with all products that have both network and non-network levels of benefits. Include for all new and renewing groups effective on or after program launch date of 1/1/18. **Diabetic Self-Management Items:** [1]Include when the plan design contains an *Outpatient Prescription Drug Rider*. [2]Include when the plan design provides the *Durable Medical Equipment* Benefit. [3]Include when the plan design does not contain an *Outpatient Prescription Drug Rider*. [4]Include when the plan design does not provide the *Durable Medical Equipment* Benefit.
12-14	*Durable Medical Equipment*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design does not include the *Orthotic Devices* Benefit. [2]Include when the plan design provides coverage for speech aid devices and tracheo-esophageal voice devices. [3]Include when the plan design has tiers and the tiers are not listed in the *Certificate of Coverage*. [4]Include when the plan design has tiers and the tiers are listed in the *Certificate of Coverage*.
14	*Emergency Health Services - Outpatient*	Include when the plan design provides for retrospective review of Emergency services.
14-15	*Hearing Aids*	[1]Include when the plan design provides hearing aid coverage for Covered persons.
16	*Infertility Services*	Optional Benefit the Enrolling Group can select.

CERTIFICATE OF COVERAGE - SECTION 1: COVERED HEALTH SERVICES		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
16-17	*Lab, X-Ray and Diagnostics - Outpatient*	[1]Include when the plan design covers these services when they are performed in a Physician's office under this Benefit. [2]Include when the plan design covers these services when performed in a Physician's office under the *Physician's Office Services - Sickness and Injury* Benefit.
17	*Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*	[1]Include when the plan design covers these services when they are performed in a Physician's office under this Benefit. [2]Include when the plan design covers these services when they are performed in a Physician's office under the *Physician's Office Services - Sickness and Injury* Benefit.
18-19	*Obesity Surgery*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design requires a BMI of more than 40. [2]Include when the plan design requires that either criterion be met.
19	*Ostomy Supplies*	Optional Benefit the Enrolling Group can select.
19-20	*Pharmaceutical Products - Outpatient*	[1]Include when the plan design provides coverage for *Infertility Services*. [2]Include when the plan design has tiers for Pharmaceutical Products. [3]Include when the plan requires the purchase of certain Pharmaceutical Products from a Designated Dispensing Entity. [4]Include when the plan design includes specialty Pharmaceutical Products. [5]Include when the plan design is the Choice Plus product. [6]Include when the plan has step therapy. [7]Include when the plan design has supply limits for certain Pharmaceutical Products.
20-21	*Physician's Office Services - Sickness and Injury*	[1]Include when the plan design requires Genetic Testing to be preceded by genetic counseling. [2]Include when the plan design covers Benefits for lab, radiology/X-ray or other diagnostic services performed in the Physician's office under this Benefit. [3]Include when the plan design covers major diagnostics performed in a Physician's office under the major diagnostic category. [4]Include when the plan design covers tests or samples

CERTIFICATE OF COVERAGE - SECTION 1: COVERED HEALTH SERVICES		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		drawn in the Physician's office and sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services performed outside the Physician's office under the *Lab, X-Ray and Diagnostics -Outpatient* Benefit.
21-22	*Preventive Care Services*	[1]Include when the plan design requires breast pumps to be ordered by or provided by a Physician and/or information on how to access Benefits for breast pumps is available online. [2]Include when the plan design requires breast pumps to be ordered by or provided by a Physician. [3]Include when information on how to access Benefits for breast pumps is online.
23	*Prosthetic Devices*	Optional Benefit the Enrolling Group can select.
23-25	*Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]*	Optional Benefit the Enrolling Group can select. [1]Include when the plan covers Manipulative Treatment. [2]Include when the plan design includes Essential Health Benefits. [3]Include when the plan covers vision therapy.
25-26	*Scopic Procedures - Outpatient Diagnostic and Therapeutic*	[1]Include when the plan covers these services when they are performed in a Physician's office under this Benefit. [2]Include when the plan covers these services when they are performed in a Physician's office under the *Physician's Office Services - Sickness and Injur*y Benefit.
27	*Substance Use Disorder Services*	Include when plan design includes coverage for transitional living services.
27	*Surgery - Outpatient*	[1]Include when the plan covers these services when they are performed in a Physician's office under this Benefit. [2]Include when the plan design contains examples of surgical procedures performed in a Physician's office. [3]Include when the plan design covers these services when they are performed in a Physician's office under the *Physician's Office Services - Sickness and Injur*y Benefit.
28	*Temporomandibular Joint Disorder*	Optional Benefit the Enrolling Group can select.
29	*Therapeutic Treatments - Outpatient*	[1]Include when the plan design covers these services when they are performed in a Physician's office under this Benefit. [2]Include when the plan covers these services when they are performed in a Physician's office under the

CERTIFICATE OF COVERAGE - SECTION 1: COVERED HEALTH SERVICES		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		*Physician's Office Services - Sickness and Injur*y Benefit.
29	*Vision Examinations*	Optional Benefit the Enrolling Group can select. [1]Include when the plan design is set up to avoid double coverage for pediatric vision Benefits which may be covered under the *Pediatric Vision Care Services Rider* or if the group is covering them under a stand-alone vision plan. [2]Include when the plan design covers pediatric vision Benefits under the *Pediatric Vision Care Services Rider*.
29	*Virtual Visits*	Optional Benefit the Enrolling Group can select.

CERTIFICATE OF COVERAGE - SECTION 2: EXCLUSIONS AND LIMITATIONS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
31-32	*C. Devices, Appliances and Prosthetics*	[1]Include when the plan design provides Benefits for speech aid devices and tracheo-esophageal voice devices under the *Durable Medical Equipment* Benefit. [2]Include when the plan design provides the *Prosthetic Devices* Benefit. [3]Include when the plan does not provide the *Prosthetic Devices* Benefit.
32	*D. Drugs*	[1]Include when the plan design does not contain an *Outpatient Prescription Drug Rider.* [2]Include when the plan design has supply limits for Pharmaceutical Products. [3]Include when the plan has tiers for Pharmaceutical Products and new Pharmaceutical Products are excluded until they are assigned to a tier.
33	*G. Medical Supplies [[1]and Equipment]*	[1]Include when the plan design does not provide the *Durable Medical Equipment* Benefit. [2]Include when the plan design does not provide the *Ostomy Supplies* Benefit. [3]Include when the plan provides the *Durable Medical Equipment* Benefit. [4]Include when the plan design provides the *Ostomy Supplies* Benefit.
36	*L. Physical Appearance*	[1]Include when the plan design does not provide Benefits for weight loss programs.

CERTIFICATE OF COVERAGE - SECTION 2: EXCLUSIONS AND LIMITATIONS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
37-38	*M. Procedures and Treatments*	[1]Include when the plan design provides the *Rehabilitation Services - Outpatient Therapy* Benefit. [2]Include when the plan design provides *Manipulative Treatment* as a part of the *Rehabilitation Services - Outpatient Therapy* Benefit. [3]Include when the plan design the does not provide the *Rehabilitation Services - Outpatient Therapy* Benefit. [4]Include when the plan design does not provide the *Manipulative Treatment* Benefit. [5]Include when the plan design does not cover surgical or non-surgical treatment of obesity. [6]Include when the plan design provides coverage for surgical treatment of obesity. [7]Include when the plan design does not provide coverage for surgical treatment of obesity. [8]Include when the plan design does not provide coverage for breast reduction. [9]Include when the plan design provides coverage for breast reduction. [10]Include when the plan design provides the *Infertility Services* Benefit. [11]Include when the plan design does not provide the *Infertility Services* Benefit. [12]Include when the plan design requires the implantation of ventricular assist devices to be performed at a Designated Facility. [13]Include when the plan design requires the implantation of ventricular assist devices to be performed at a Designated Facility to receive Network Benefits.
39	*O. Reproduction*	[1]Include when the plan design does not provide the *Infertility Services* Benefit. [2]Include when the plan design provides the *Infertility Services* Benefit.
40	*S. Transplants*	[1]Include when the plan design requires transplants to be performed in a Designated Facility.
42	*S. Travel*	[1]Include when the plan design does not provide coverage for services performed outside the United States and its territories.

CERTIFICATE OF COVERAGE - SECTION 2: EXCLUSIONS AND LIMITATIONS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
41	*V. Vision and Hearing*	[1]Include when the plan design does not provide coverage for routine vision examinations. [2]Include when the plan design does not provide coverage for vision therapy. [3]Include when the plan design provides Benefits for hearing aids.
41-42	*W. All Other Exclusions*	[1]Include when the plan design does not provide coverage for immunizations for travel and/or career or employment. Modify text as applicable.

CERTIFICATE OF COVERAGE - SECTION 3: WHEN COVERAGE BEGINS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
	Medicare Estimating	Include when the plan design includes Medicare estimating.
43	*Eligible Person*	[1]Include when the plan provides coverage for only Eligible Persons residing within the United States. [2]Include when the plan design does not provide double coverage.
43	*Dependent*	Include when the plan design does not provide double coverage.
44	*Open Enrollment Period*	Include when the plan design has an Open Enrollment Period.
44	*Adding New Dependents*	[1]Include when the plan requires registering a Domestic Partner.
45	*Special Enrollment Period*	[1]Include when the plan requires registering a Domestic Partner. [2]Include when the plan design has an Open Enrollment Period.

CERTIFICATE OF COVERAGE - SECTION 4: WHEN COVERAGE ENDS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
46	*Events Ending Your Coverage*	[1]Include the optional date that coverage will end as selected by the Enrolling Group.

CERTIFICATE OF COVERAGE - SECTION 4: WHEN COVERAGE ENDS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
47	*Extended Coverage for Total Disability*	Include when plan includes disability coverage.

CERTIFICATE OF COVERAGE - SECTION 5: HOW TO FILE A CLAIM		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
49	*Required Information*	[1]Include when the plan design the Enrolling Group selects contains an *Outpatient Prescription Drug Rider*. Modify text as applicable.
50	*Payment of Benefits*	[1]Include when the plan design contains a provision for assignment of Benefits. [2]Include when the plan design does not contain a provision for assignment of Benefits.

CERTIFICATE OF COVERAGE - SECTION 7: COORDINATION OF BENEFITS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
59-60	*Medicare Estimating*	Include when the plan includes Medicare estimating.

CERTIFICATE OF COVERAGE - SECTION 8: GENERAL LEGAL PROVISIONS		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
64	*Rebates and Other Payments*	[1]Include if rebates are not passed on to the Covered Person. [2]Include if rebates are passed on to the Covered Person.
66-66	*Medicare Eligibility*	Include when the plan includes Medicare estimating.

CERTIFICATE OF COVERAGE - SECTION 9: DEFINED TERMS		
PAGE NUMBER(S)	**DEFINITION**	**VARIABLE USE**
69	*Assisted Reproductive Technology (ART)*	Include when the plan design provides the *Infertility Services* Benefit.

CERTIFICATE OF COVERAGE - SECTION 9: DEFINED TERMS		
PAGE NUMBER(S)	**DEFINITION**	**VARIABLE USE**
69	*Coinsurance*	Include when the plan design has tiers for the Pharmaceutical Products.
69-70	*Copayment*	Include when the plan design has tiers for the Pharmaceutical Products.
70-71	*Dependent*	[1]Include when the Enrolling Group elects to provide coverage for Domestic Partners. [2]Include when the Enrolling Group elects to provide coverage for parents, grandparents and/or other sponsored Dependents. Modify text as applicable. [3]Include when the plan provides coverage for only Eligible Persons residing within the United States. [4]The age is modified to accommodate the Enrolling Group's decision on the limiting age. [5]Include when the Enrolling Group elects to provide coverage for a Dependent child until the last day of the year the child reaches the limiting age. [6]Include when the plan design the Enrolling Group selects does not provide for double coverage.
71	*Designated Dispensing Entity*	Include when the plan design requires Pharmaceutical Products to be obtained from a Designated Dispensing Entity.
71	*Domestic Partner*	[1]Include when the Enrolling Group elects to provide coverage for Domestic Partners. Modify text as applicable.
72	*Domestic Partnership*	Include when the Enrolling Group elects to provide coverage for Domestic Partners. [1]The text is modified to include the Enrolling Group's choices for Domestic Partners. [2]Include when the Enrolling Group requires documentation of financial interdependence. [3]Include the number of months required for a dedicated relationship as selected by the Enrolling Group. [4]Include when the Enrolling Group requires a signed affidavit.
74	*Manipulative Treatment*	Include when the plan design includes Benefits for *Manipulative Treatment*.
75	*Mobility Device*	Include when the plan design includes Benefits for mobility devices.
75	*Network*	Include when the plan design contains the Shared Savings Program.

CERTIFICATE OF COVERAGE - SECTION 9: DEFINED TERMS		
PAGE NUMBER(S)	**DEFINITION**	**VARIABLE USE**
75-76	*New Pharmaceutical Product*	Include when the plan design does not cover New Pharmaceutical Products.
76	*Open Enrollment Period*	Include when the plan design has an Open Enrollment Period.
76	*Per Occurrence Copayment*	Include when the plan design has a Per Occurrence Copayment.
77	*Primary Physician*	Include when the plan design provides the *Manipulative Treatment* Benefit.
78	*Rider*	Include when the plan design includes the *Outpatient Prescription Drug Rider, Pediatric Dental Services Rider* and/or *Pediatric Vision Care Services Rider.* Modify text as applicable.
78	*Shared Savings Program*	Include when the plan design contains the Shared Savings Program. [1]Include when participation status of a non-Network provider in the Shared Savings Program is available on the website.
78	*Specialist Physician*	Include when the plan design provides the *Manipulative Treatment* Benefit.
78	*Total Disability or Totally Disabled*	Applies when group purchases extended coverage for total disability.

UnitedHealthcare Insurance Company

Statement of Variability
for
Performance Rewards Amendment – Form No. POL.AMD.PR.I.11.DC

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as indicated below.

When there is variable language within the *Performance Rewards Amendment*, superscript numbers ([1]) have been added for ease of reference in the *Amendment* and in the table below. These superscript numbers will be removed and will not appear in the *Performance Rewards Amendment* issued to the Enrolling Group.

The *Performance Rewards Amendment* contains various numerical ranges. These ranges will be used to indicate dollars, number of days and percentages. The numbers entered in the *Performance Rewards Amendment* will be based on the selections of the Enrolling Group. The ranges indicate the lowest and highest values and allow any value in between the lowest and highest to be used.

Specific Variable Information

The following table provides a description of how and/or when each variable in the *Performance Rewards Amendment* will be used.

PERFORMANCE REWARDS AMENDMENT		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
1	*Top of the Page*	Performance Rewards is bracketed throughout the amendment in case the program name were to change.
1-3	*Performance Rewards Amendment*	Variable provisions apply when advance payment is supported in Exhibit 1.
1	*Payment of the Policy Charge*	Include when grace period provision applies. [1]Include when grace period provision does not apply.
1-2	*Glossary of Defined Terms*	[1]Insert the number of months that Performance Rewards is to be in effect (standard is 12, but could range from a minimum of 6 to a maximum of 18). [2]Insert the Administration Fee. [3]Applies when limit per covered person is included (pooling point). When included, the 'pooling" definition below applies. [4]Insert the % of the current year's Adjusted Policy Charge that will be held for claim reserve. [5]Insert % of the prior year's Adjusted Policy Charge that

PERFORMANCE REWARDS AMENDMENT		
PAGE NUMBER(S)	**SUBSECTION TITLE**	**VARIABLE USE**
		was held for claim reserve. If New Business, enter “0%”. [6]Applies when a pooling charge is included. [7]Applies when charge is per covered person per month. [8]Applies when charge is a percentage of the policy charge due.
2-3	*Performance Rewards*	[1]Insert % of the excess amount that is credited. The standard is 50%. [2]Insert the maximum % of the Policy Charge due that will be credited. The standard is 8%.

UnitedHealthcare Insurance Company
Statement of Variability
for
Outpatient Prescription Drug Rider
(Form No. RDR.RX.PLS.17.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Outpatient Prescription Drug Rider* and in the table below. These superscript numbers will be removed and will not appear in the *Outpatient Prescription Drug Rider* issued to the Enrolling Group.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Outpatient Prescription Drug Rider* will be used.

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
2	*Coverage Policies and Guidelines*	[1]Include when the plan design requires notification. [2]Include when the plan design requires prior authorization.
2	*Identification Card (ID Card) - Network Pharmacy*	[1]Include when the plan design contains the mandatory or restrictive generic program. [2]Include when the plan design has a Therapeutic Class Charge. [3]Include when the plan design has a Therapeutically Equivalent Charge.
3	*Designated Pharmacies*	[1]Include when the plan design contains the Designated Pharmacy program. [2]Include when the plan design contains the specialty drug program. [3]Include Smart Fill Program language if included in plan design.
3-4	*Rebates and Other Payments*	Variable provision supports plan designs that include an annual drug deductible or a specialty prescription drug annual deductible and plan designs that are combined medical/RX plans. [1]Applies when rebates are passed on to customers. [2]Applies when rebates are not passed on to customers.
4	*Maintenance Medication Program*	Include when the plan design has mail order and the Maintenance Medication program.

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
4	*Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans*	Include when the plan design has a combined medical and pharmacy deductible plan and an incentive program.
6	*Section 1: Benefits for Prescription Drug Products - Introductory Paragraphs*	[1]Include when the plan design has closed panel Benefits. [2]Include when "Refill Too Soon" program applies.
6	*Section 1: Benefits for Prescription Drug Products - Specialty Prescription Drug Products*	[1]Include when the plan design contains the specialty drug program. [2]Include when the plan design contains the Designated Pharmacy program.
6-7	*Section 1: Benefits for Prescription Drug Products - Prescription Drug Products from a Mail Order Network Pharmacy*	Include when the plan design covers mail order Prescription Drug Products.
8-10	*Section 2: Exclusions*	[1]Include when the plan design does not cover non-Emergency drugs dispensed outside the United States. [2]Include when the plan design does not cover weight loss products. [3]Include when the plan design covers immunizations administered in a pharmacy. Include applicable pharmacy or combination of pharmacies. [4]Include when the plan design does not cover drugs to treat infertility. [5]Include when the plan design does not cover treatment of toenail fungus. [6]Include when the plan design does not cover drugs for smoking cessation. The variable "Certain" is used when the plan design only excludes certain smoking cessation drugs. [7]Include when the plan design is subject to any Essential Health Benefits that require coverage for smoking cessation products to be *PPACA* compliant. [8]Include when the plan design has closed panel Benefits. Modify text to include applicable tiers where appropriate. [9]Include when the plan design does not cover drugs prescribed by a non-Network Physician or a non-Network provider. [10]Include when the plan design covers compounded drugs. Modify text to include applicable tiers. [11]Include when the plan design does not cover

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
		compounded drugs. [12]Include when the plan design does not cover over-the-counter drugs unless designated as covered. [13]Include when the plan design covers over-the-counter drugs that are designated as covered and require a Prescription Order or Refill. [14]Include when the plan design covers over-the-counter drugs for smoking cessation. [15]Include when the plan design does not cover certain new prescription drugs until they are assigned to a tier. [16]Include when the plan design does not cover growth hormone therapy for any condition. [17]Include when the plan design does not cover growth hormone therapy for familial short stature. [18]Include when the plan design does not cover oral non-sedating antihistamine or antihistamine-decongestant combination. [19]Include when the plan design does not cover drugs for erectile or sexual dysfunction. [20]Include when the plan design does not cover a particular Therapeutic Class or Therapeutic Classes. [21]Include when the plan design does not cover drugs used to adjust sleep schedules. [22]Include when the plan design the plan design does not cover drugs prescribed as sleep aids. [23]Include when the plan design does not cover drugs that contain an active ingredient available in and Therapeutically Equivalent to another covered drug. [24]Include when the plan design does not cover prescription drugs that are both a modified version of and Therapeutically Equivalent to another prescription drug. [25]Include when the plan design does not cover marijuana. [26]Include when the plan design is subject to *PPACA* Essential Health Benchmark Plan requirements.
11-14	*Section 3: Defined Terms*	[1]Include when the plan design contains the mandatory or restrictive generic program. [2]Include when the plan design contains the mandatory generic program. [3]Include when the plan design has an Annual Drug Deductible. Modify text to include applicable tiers. [4]Include when the plan design contains the Designated

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
		Pharmacy program. [5]Include when the plan design contains the specialty drug program. [6]Include when the plan design covers infertility. [7]Include when the plan design has an Infertility Annual Maximum Benefit. [8]Include when the plan design has an Infertility Maximum Policy Benefit. [9]Include when the plan design provides coverage for Prescription Drug Products on the List of Preventive Medications. [10]Include when the plan design has mail order and the Maintenance Medication program. [11]Include when the plan design has mail order and Maximum Allowable Cost List pricing. [12]Include when the plan design has increased Copayments and/or Coinsurance when a mail order pharmacy identified as a non-preferred pharmacy within the Network is used. [13]Include when the plan design has increased Copayments and/or Coinsurance when a retail pharmacy identified as a non-preferred pharmacy within the Network is used. [14]Include when the plan design has Copayments and/or Coinsurance that are limited by an Out-of-Pocket Maximum. [15]Include when the plan design has reduced Copayments and/or Coinsurance when a mail order pharmacy identified as a preferred pharmacy within the Network is used. [16]Include when the plan design has reduced Copayments and/or Coinsurance when a retail pharmacy identified as a preferred pharmacy within the Network is used. [17]Include when the plan design covers immunizations administered in a pharmacy. [18]Include when the plan design requires a Prescription Order or Refill from a Physician. [19]Include either option based on the plan design the Enrolling Group selects. Modify text as applicable. [20]Include when the plan design contains certain drugs for infertility. [21]Include when the plan design contains specialty drugs on the List of Preventive Medications. [22]Include when the plan design has a Specialty

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
		Prescription Drug Product Annual Deductible. Modify text as applicable. [23]Include when the plan design has a Specialty Prescription Drug Product Out-of-Pocket Maximum. [24]Include when the plan design has Copayment, Coinsurance, ancillary charges or exclusion by Therapeutic Class. [25]Include when the plan design has a Therapeutic Class Charge. [26]Include when the plan design has a Therapeutically Equivalent Charge.

UnitedHealthcare Insurance Company
Statement of Variability
for
Outpatient Prescription Drug Rider
(Form No. RDR.RX.NET.17.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Outpatient Prescription Drug Rider* and in the table below. These superscript numbers will be removed and will not appear in the *Outpatient Prescription Drug Rider* issued to the Enrolling Group.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Outpatient Prescription Drug Rider* will be used.

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
2	*Coverage Policies and Guidelines*	[1]Include when the plan design requires notification. [2]Include when the plan design requires prior authorization.
2	*Identification Card (ID Card) - Network Pharmacy*	[1]Include when the plan design contains the mandatory or restrictive generic program. [2]Include when the plan design has a Therapeutic Class Charge. [3]Include when the plan design has a Therapeutically Equivalent Charge.
3	*Designated Pharmacies*	[1]Include when the plan design contains the Designated Pharmacy program. [2]Include when the plan design contains the specialty drug program. [3]Include Smart Fill Program language if included in plan design.
3-4	*Rebates and Other Payments*	Variable provision supports plan designs that include an annual drug deductible or a specialty prescription drug annual deductible and plan designs that are combined medical/RX plans. [1]Applies when rebates are passed on to customers. [2]Applies when rebates are not passed on to customers.
4	*Maintenance Medication Program*	Include when the plan design has mail order and the Maintenance Medication program.

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
4	*Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans*	Include when the plan design has a combined medical and pharmacy deductible plan and an incentive program.
6	*Section 1: Benefits for Prescription Drug Products - Introductory Paragraphs*	[1]Include when the plan design has closed panel Benefits. [2]Include when "Refill Too Soon" program applies.
6	*Section 1: Benefits for Prescription Drug Products - Specialty Prescription Drug Products*	[1]Include when the plan design contains the specialty drug program. [2]Include when the plan design contains the Designated Pharmacy program.
6-7	*Section 1: Benefits for Prescription Drug Products - Prescription Drug Products from a Mail Order Network Pharmacy*	Include when the plan design covers mail order Prescription Drug Products.
8-10	*Section 2: Exclusions*	[1]Include when the plan design does not cover non-Emergency drugs dispensed outside the United States. [2]Include when the plan design does not cover weight loss products. [3]Include when the plan design covers immunizations administered in a pharmacy. Include applicable pharmacy or combination of pharmacies. [4]Include when the plan design does not cover drugs to treat infertility. [5]Include when the plan design does not cover treatment of toenail fungus. [6]Include when the plan design does not cover drugs for smoking cessation. The variable "Certain" is used when the plan design only excludes certain smoking cessation drugs. [7]Include when the plan design is subject to any Essential Health Benefits that require coverage for smoking cessation products to be *PPACA* compliant. [8]Include when the plan design has closed panel Benefits. Modify text to include applicable tiers where appropriate. [9]Include when the plan design does not cover drugs prescribed by a non-Network Physician or a non-Network provider. [10]Include when the plan design covers compounded drugs. Modify text to include applicable tiers. [11]Include when the plan design does not cover

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
		compounded drugs. [12]Include when the plan design does not cover over-the-counter drugs unless designated as covered. [13]Include when the plan design covers over-the-counter drugs that are designated as covered and require a Prescription Order or Refill. [14]Include when the plan design covers over-the-counter drugs for smoking cessation. [15]Include when the plan design does not cover certain new prescription drugs until they are assigned to a tier. [16]Include when the plan design does not cover growth hormone therapy for any condition. [17]Include when the plan design does not cover growth hormone therapy for familial short stature. [18]Include when the plan design does not cover oral non-sedating antihistamine or antihistamine-decongestant combination. [19]Include when the plan design does not cover drugs for erectile or sexual dysfunction. [20]Include when the plan design does not cover a particular Therapeutic Class or Therapeutic Classes. [21]Include when the plan design does not cover drugs used to adjust sleep schedules. [22]Include when the plan design the plan design does not cover drugs prescribed as sleep aids. [23]Include when the plan design does not cover drugs that contain an active ingredient available in and Therapeutically Equivalent to another covered drug. [24]Include when the plan design does not cover prescription drugs that are both a modified version of and Therapeutically Equivalent to another prescription drug. [25]Include when the plan design does not cover marijuana. [26]Include when the plan design is subject to *PPACA* Essential Health Benchmark Plan requirements.
11-14	*Section 3: Defined Terms*	[1]Include when the plan design contains the mandatory or restrictive generic program. [2]Include when the plan design contains the mandatory generic program. [3]Include when the plan design has an Annual Drug Deductible. Modify text to include applicable tiers. [4]Include when the plan design contains the Designated

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
		Pharmacy program. [5]Include when the plan design contains the specialty drug program. [6]Include when the plan design covers infertility. [7]Include when the plan design has an Infertility Annual Maximum Benefit. [8]Include when the plan design has an Infertility Maximum Policy Benefit. [9]Include when the plan design provides coverage for Prescription Drug Products on the List of Preventive Medications. [10]Include when the plan design has mail order and the Maintenance Medication program. [11]Include when the plan design has mail order and Maximum Allowable Cost List pricing. [12]Include when the plan design has increased Copayments and/or Coinsurance when a mail order pharmacy identified as a non-preferred pharmacy within the Network is used. [13]Include when the plan design has increased Copayments and/or Coinsurance when a retail pharmacy identified as a non-preferred pharmacy within the Network is used. [14]Include when the plan design has Copayments and/or Coinsurance that are limited by an Out-of-Pocket Maximum. [15]Include when the plan design has reduced Copayments and/or Coinsurance when a mail order pharmacy identified as a preferred pharmacy within the Network is used. [16]Include when the plan design has reduced Copayments and/or Coinsurance when a retail pharmacy identified as a preferred pharmacy within the Network is used. [17]Include when the plan design covers immunizations administered in a pharmacy. [18]Include when the plan design requires a Prescription Order or Refill from a Physician. [19]Include either option based on the plan design the Enrolling Group selects. Modify text as applicable. [20]Include when the plan design contains certain drugs for infertility. [21]Include when the plan design contains specialty drugs on the List of Preventive Medications. [22]Include when the plan design has a Specialty

OUTPATIENT PRESCRIPTION DRUG RIDER		
PAGE NUMBER(S)	**SUBSECTION TITLE OR EXHIBIT**	**VARIABLE USE**
		Prescription Drug Product Annual Deductible. Modify text as applicable. [23]Include when the plan design has a Specialty Prescription Drug Product Out-of-Pocket Maximum. [24]Include when the plan design has Copayment, Coinsurance, ancillary charges or exclusion by Therapeutic Class. [25]Include when the plan design has a Therapeutic Class Charge. [26]Include when the plan design has a Therapeutically Equivalent Charge.

UnitedHealthcare Insurance Company

Statement of Variability
for
Outpatient Prescription Drug Schedule of Benefits
(Form No. RDR.RXSBN.PLS.17.I.11.LG.DC)

General Variable Information

When text is bracketed, the bracketed area will either be included in its entirety or removed in its entirety as determined by the plan design selected by the Enrolling Group.

When there is variable language within a variable or more than one variable within a subsection, superscript numbers ([1]) have been added for ease of reference in the *Outpatient Prescription Drug Schedule of Benefits* and in the table below. These superscript numbers will be removed and will not appear in the *Outpatient Prescription Drug Rider* issued to the Enrolling Group.

The *Outpatient Prescription Drug Schedule of Benefits* contains various numerical ranges. These ranges will be used to indicate Copayments, Coinsurance and tiers. The variable provisions will allow for different Copayments and/or Coinsurance on each tier. These variable provisions will also allow for different Copayments and/or Coinsurance for growth hormone therapy, therapeutic classes, and preventive medications within each tier. The number of tiers, Copayments and/or Coinsurance used in the *Outpatient Prescription Drug Schedule of Benefits* will be determined by the plan design the Enrolling Group selects. The ranges indicate the lowest and highest values and allow any value in between the lowest and highest to be used depending on the plan design the Enrolling Group selects.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the *Outpatient Prescription Drug Schedule of Benefits* will be used.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
1	*Benefits for Prescription Drug Products*	[1]Include when the plan design has closed panel Benefits.
1	*If a Brand-name Drug Becomes Available as a Generic*	[1]Include when the plan design has open panel Benefits. [2]Include when the plan design contains the mandatory or restrictive generic program. [3]Include when the plan design has closed panel Benefits.
2-3	*[Notification] [Prior Authorization] Requirements*	[1]Include when the plan design requires notification. [2]Include when the plan design requires prior authorization. [3]Include when the plan design contains the mandatory or restrictive generic program. [4]Include when the plan design has a Therapeutic Class Charge. [5]Include when the plan design has a Therapeutically

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		Equivalent Charge.
3	*Step Therapy*	[1]Include when the plan design applies step therapy requirements.
3-4	*What You Must Pay*	[1]Include when the plan design has an Annual Drug Deductible and/or a Specialty Prescription Drug Product Annual Deductible. Include "and" if applicable. [2]Include when the plan design does not apply Prescription Drug Products on the List of Preventive Medications to the Annual Drug Deductible. [3]Include when the plan design does not apply Preventive Care Medications to the Annual Drug Deductible. Required for non-grandfathered plans under Federal PPACA. [4]Include when the plan design does not apply insulin or diabetic supplies to the Annual Drug Deductible. Include "or" if applicable. [5]Include when the plan design has an Annual Deductible that combines medical and prescription drug Benefits. [6]Include when the plan design does not apply Prescription Drug Products on the List of Preventive Medications to the Annual Deductible. [7]Include when the plan design does not apply Preventive Care Medications to the Annual Deductible. Required for non-grandfathered plans under Federal PPACA. [8]Include when the plan design does not apply insulin or diabetic supplies to the Annual Deductible. Include "or" if applicable. [9]Include when the plan design contains the mandatory or restrictive generic program (Ancillary Charge). Modify text as applicable. [10]Include when the plan design has a Therapeutic Class Charge. [11]Include when the plan design has a Therapeutically Equivalent Charge. [12]Include when the plan design contains the mandatory generic program. [13]Include based on plan design those items that are not applied to the Out-of-Pocket Maximum stated in the applicable *Certificate of Coverage*.
5	*Payment Information*	[1]Include when the plan design calculates Benefits on a calendar year basis. [2]Include when the plan design calculates benefits on a

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		Policy year basis. [3]Include the applicable provisions based on the plan design.
5-6	*Annual Drug Deductible*	[1]Include when the plan design has an Annual Drug Deductible. Include either Option 1 or Option 2 as shown in [2] and [3] below. [2]Include when the plan design uses Option 1. Option 1 applies when the Annual Drug Deductible is determined based on Network or Non-Network status. Modify text based on the plan design. [3]Include when the plan design uses Option 2. Option 2 applies when the Annual Drug Deductible is determined based on tier status. Modify text based on the plan design. [4]Include when the plan design does not apply Prescription Drug Products on the List of Preventive Medications to the Annual Drug Deductible. [5]Include when the plan design does not apply Preventive Care Medications to the Annual Drug Deductible. [6]Include when the plan design does not apply insulin and/or diabetic supplies to the Annual Drug Deductible. Include "or" if applicable. [7]Include when the plan design has an Annual Drug Deductible carry-over provision. Modify text to reflect whether Benefits are calculated on a calendar or Policy year basis. [8]Include when the plan design applies the carry-over provision to only the individual Annual Drug Deductible. [9]Include when the plan design applies an Annual Drug Deductible roll-over provision. [10]Include when the plan design applies the roll-over provision to the Annual Drug Deductible and the plan changes from a calendar to a Policy year plan. [11]Include when the plan design applies the roll-over provision to only the individual Annual Drug Deductible. [12]Include when the plan design may not permit certain coupons/offers from pharmaceutical manufacturers to apply to the Annual Drug Deductible. [13]These variable options are used with Option 1. Modify text based on the plan design. [14]Include when the plan design does not have an Annual Drug Deductible. [15]Include when the plan design has an individual Annual Drug Deductible.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		[16]Include when the plan design has an individual (with family maximum) Annual Drug Deductible. [17]These variable options are used with Option 2. Modify text based on the plan design.
6-8	*Specialty Prescription Drug Product Annual Deductible*	[1]Include when the plan design has a Specialty Prescription Drug Product Annual Deductible. Include either Option 1 or Option 2 as shown in [2] and [3] below. [2]Include when the plan design uses Option 1. Option 1 applies when the Specialty Prescription Drug Product Annual Deductible is based on either specialty drug product, per specialty drug product, per therapeutic class and/or growth hormone therapy. Modify text based on the plan design. [3]Include when the plan design uses Option 2. Option 2 applies when the Specialty Prescription Drug Product Annual Deductible is determined based on tier status. Modify text based on the plan design. [4]Include when the plan design has a Specialty Prescription Drug Product Annual Deductible carry-over provision. Modify text to reflect whether Benefits are calculated on a calendar or Policy year basis. [5]Include when the plan design applies the carry-over provision to only the individual Specialty Prescription Drug Product Annual Deductible. [6]Include when the plan design applies a Specialty Prescription Drug Product Annual Deductible roll-over provision. [7]Include when the plan design applies the roll-over provision to the Specialty Prescription Drug Product Annual Deductible and the plan changes from a calendar to a Policy year plan. [8]Include when the plan design applies the roll-over provision to only the individual Specialty Prescription Drug Product Annual Deductible. [9]Include when the plan design includes the Specialty Prescription Drug Product Annual Deductible in the overall Annual Drug Deductible. [10]Include when the plan design may not permit certain coupons/offers from pharmaceutical manufacturers to apply to the Specialty Drug Product Annual Deductible. [11]These variable options are used with Option 1. Modify text based on the plan design. [12]Include when the plan design has an individual Specialty Prescription Drug Product Annual Deductible. [13]Include when the plan design has an individual (with family maximum) Specialty Prescription Drug Product

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		Annual Deductible. [14]Include when the plan design not have a Specialty Prescription Drug Product Annual Deductible. Modify text to include applicable tiers. [15]These variable options are used with Option 2. Modify text based on the plan design.
8-9	*Out-of-Pocket Drug Maximum*	[1]Include when the plan design has an Out-of-Pocket Drug Maximum. [2]Include when the plan design applies the Out-of-Pocket Drug Maximum annually. Modify text as applicable. [3]Include when the plan design applies the Out-of-Pocket Drug Maximum monthly. Modify text as applicable. [4]Include when the plan design does not limit Copayments and/or Coinsurance for Specialty Drug Products by the Out-of-Pocket Drug Maximum. [5]Include when the plan design does not limit Copayments and/or Coinsurance for Specialty Drug Products for infertility by the Out-of-Pocket Drug Maximum. [6]Include when the plan design has an individual Out-of-Pocket Drug Maximum. [7]Include when the plan design has an individual (with family maximum) Out-of-Pocket Drug Maximum. [8]Include when the plan design does not apply the Copayments and Coinsurance to the Out-of-Pocket Drug Maximum. [9]Include when the plan design has an Annual Drug Deductible. Modify text to include or not include the Annual Drug Deductible in the Out-of-Pocket Drug Maximum.
9-10	*Specialty Prescription Drug Product Out-of-Pocket Maximum*	[1]Include when the plan design has a Specialty Prescription Drug Product Out-of-Pocket Maximum. [2]Include when the plan design applies the Specialty Prescription Drug Product Out-of-Pocket Maximum annually. Modify text as applicable. [3]Include when the plan design applies the Specialty Prescription Drug Product Out-of-Pocket Maximum monthly. Modify the text as applicable. [4]Include when the plan design does not limit Specialty Prescription Drug Products for infertility by the Specialty Prescription Drug Product Out-of-Pocket Maximum. [5]Include when the plan design has an individual Specialty Prescription Drug Pocket Out-of-Pocket Maximum.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		[6]Include when the plan design has an individual (with family maximum) Specialty Prescription Drug Product Out-of-Pocket Maximum. [7]Include when the plan design has a Specialty Prescription Drug Product Annual Deductible. Modify text to include or not include the Specialty Prescription Drug Product Annual Deductible in the Specialty Prescription Drug Product Out-of-Pocket Maximum. [8]Include when the plan design does not apply the Copayments and Coinsurance to the Specialty Prescription Drug Out-of-Pocket Drug Maximum.
10	*Infertility Annual Maximum Benefit*	[1]Include when the plan design has an Infertility Annual Maximum Benefit.
10	*Infertility Maximum Policy Benefit*	[1]Include when the plan design has an Infertility Maximum Policy Benefit.
10-13	*Copayment and Coinsurance*	[1]Include when the plan design applies regimen pricing to therapeutic treatments. [2]Include when the plan design contains the enhanced Benefits program. Modify text to include the applicable notification or prior authorization requirements. [3]Include when the plan design has the Copayment/Coinsurance Waiver Program. [4]Include applicable text. [5]Include when the plan design has a Prescription Drug Charge. [6]Include when the plan design contains the mail order pharmacy Benefit. [7]Include when the plan design does not require a Copayment and/or Coinsurance for Preventive Care Medications.
14-19	*Specialty Prescription Drug Products*	[1]Include when the plan design contains Benefits for Specialty Prescription Drug Products. [2]Modify text based on plan design. [3]Include when the plan design has closed panel Benefits.
19-24	*Prescription Drugs from a Retail Network Pharmacy*	[1]Include when the plan design provides 90-day generic drug coverage. [2]Include when the plan design has Preferred and/or Non-Preferred Retail Pharmacy Benefits. Modify the text as applicable. [3]Include when the plan design has a Preferred Retail Network Pharmacy Benefit and Copayments or Coinsurance decrease when prescription drugs are

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS		
PAGE NUMBER(S)	**EXHIBIT**	**VARIABLE USE**
		obtained at the Preferred Retail Network Pharmacy. Modify text as applicable. [4]Include when the plan design has a Non-Preferred Retail Network Pharmacy Benefit and Copayments or Coinsurance increase when prescription drugs are obtained at a Non-Preferred Retail Network Pharmacy. Modify text as applicable. [5]Include when the plan design when the plan has closed panel Benefits.
24-27	*Prescription Drugs from a Retail Non-Network Pharmacy*	[1]Include when the plan design the plan has closed panel Benefits.
27-34	*Prescription Drug Products from a Mail Order Network Pharmacy*	[1]Include when the plan design contains Benefits for prescription drugs obtained from a mail order Network Pharmacy. [2]Include when the plan design includes the specialty drug program. [3]Include when the plan design contains the List of Preventive Medications. [4]Include when the plan design has 1 times Copayment and/or Coinsurance from a mail order Network Pharmacy. [5]Include when based on the plan design requires coverage at a retail pharmacy prior to using mail order coverage. Modify text as applicable. [6]Include when the plan design applies an initially limited mail day supply. Modify text as applicable. [7]Include when based on the plan design applies Copayments and/or Coinsurance for full 90-day supply. [8]Include when the plan design has a Preferred Mail Order Network Pharmacy and/or Non-Preferred Mail Order Network Pharmacy Benefits. Modify text as applicable. [9]Include when the plan design has a Preferred Mail Order Network Pharmacy Benefit and Copayments or Coinsurance decrease when prescription drugs are obtained at the Preferred Mail Order Network Pharmacy. Modify text as applicable. [10]Include when the plan design has a Non-Preferred Mail Order Network Pharmacy Benefit and Copayments or Coinsurance increase when prescription drugs are obtained at the Non-Preferred Mail Order Network Pharmacy. Modify text as applicable. [11]Include when the plan design has closed panel Benefits.

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum, including all cost sharing for Essential Health Benefits. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the network out-of-pocket maximum or to remove the network out-of-pocket maximum can only be utilized for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Any variables below that allow the cost shares under the outpatient prescription drug rider to not apply to the out-of-pocket maximum may only be utilized for grandfathered plans, or by non-grandfathered plans that include a separate out-of-pocket drug maximum (which when combined with the medical out-of-pocket maximum may not exceed the annual limitation on cost sharing required under ACA).]

[[1]Product names are variable for possible future product name change]

UnitedHealthcare [[1]Choice]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

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

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or PCP.

[[1]Include (and delete all other options 2, 3, 4 and 5) to support prior standard payment method when neither Emergent nor non-Emergent ENRP applies.]

[[1]Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Services.]

[[2]Include and delete #3 if Emergency Health Services provided by a non-Network provider are paid as member hold harmless (Emergent ENRP Option does not apply).]

[[3]Include and delete #2 if Emergency Health Services provided by a non-Network provider are not paid at billed charges (Emergent ENRP Option).]

[[2]Benefits always include Emergency Health Services that are provided by a Network or non-Network provider.]

[[3]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.**]

[[4]Include and delete #5 if non-emergent services by non-network RAPLEs at a network facility are paid as member hold harmless (Non-Emergent ENRP Option does not apply).]

[[5]Include and delete #4 if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP Option).]

[[4]For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Benefits for non-Emergency Covered Health Services include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[5] Covered Health Services that are provided at a Network facility 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.**]

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

[Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible [,] [and] Out-of-Pocket Maximum [,] [and] [Per Occurrence Deductible] requirements as all other Covered Health Services provided by Network providers.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Include when the enhanced benefits for certain procedures/clinical support is sold.]

[You may have an opportunity to received enhanced Benefits for certain procedures received at a Designated Facility and/or by a Designated Physician as described in this *Schedule of Benefits*. You can also determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* the telephone number on your ID card.]

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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

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

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

Prior Authorization

We 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 you are required to obtain prior authorization 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 and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- [Infertility services.]
- [Obesity surgery.]
- 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

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

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

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

Payment Term And Description	Amounts
Annual Deductible	
[Annual deductible is plan design variable. Include applicable provisions to support the following: *[1]Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.* *[2]Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.* *[3]Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.]* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [[1]The Annual Deductible 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 Rider*. [[2]Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[3]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] *[Include applicable provisions to support the following:* *[1]Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* *[2]Carry-over provision applies.* *[3]Roll-over provision applies in any circumstance.* *[4]Roll-over provision applies only to groups changing from calendar to policy year. [5]Include when roll-over applies only to*	*[[1]Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]* *[[2]Include when designated network and network are separate.]* ***[[1]Designated Network and Network]*** ***[[2]Designated Network]*** *[[A] Non-embedded.]* *[[B] Embedded.]* [[A] For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[[2]Network]*** *[[A] Non-embedded.]* *[[B] Embedded.]*

Payment Term And Description	Amounts
the individual deductible. *[6Include only when a per occurrence deductible applies.]* [1Amounts 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.] [2Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] [3When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] [4When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [5This roll-over feature applies only to the individual 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. [6The Annual Deductible does not include any applicable Per Occurrence Deductible.] *[Applies when cross accumulation applies to Designated Network and Network Annual Deductible]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.]	[A For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.]
[Per occurrence deductible is plan design variable.] **[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	[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]

Payment Term And Description	Amounts
Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	
Out-of-Pocket Maximum	
[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following: *[1]Includes the annual deductible.* *[2]Includes the per occurrence deductible.* *[3]Includes copayments.* *[4]Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.]* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]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 Rider*.] *[Include when plan design does not apply all copayments/coinsurance to the OOPM.]* [[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. *[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]* • [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.] *[Include when an Outpatient Prescription Drug Rider is sold*	*[[1]Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]* *[[2]Include when designated network and network are separate.]* ***[[1]Designated Network and Network]*** ***[[2]Designated Network]*** *[[A] Non-embedded.]* *[[B] Embedded.]* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].*

Payment Term And Description	Amounts
and copayments/coinsurance do not apply to the overall OOPM.] • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] *[Applies when cross accumulation applies to Designated Network and Network OOPM]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Out-of-Pocket Maximum will be applied to the Network Out-of-Pocket Maximum. Any amount you pay for Covered Health Services that is applied to the Network Out-of-Pocket Maximum will be applied to the Designated Network Out-of-Pocket Maximum.]	If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]

Payment Term And Description	Amounts
	[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[2]Network]*** *[[A] Non-embedded.]* *[[B] Embedded.]* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription*

Payment Term And Description	Amounts
	Drug Schedule of Benefits] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No 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.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the ~~Pharmaceutical Product~~Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and

Payment Term And Description	Amounts
will vary based upon the tier assignment.] 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. [For Pharmaceutical Products, your Coinsurance is determined by the tier to which the ~~Pharmaceutical Product~~Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.

- Prior authorization requirements and any penalty for failure to prior authorize

- Designated network benefit levels as applicable.

- Any other specific conditions for coverage described within the category.]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

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. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - 5,000] in Eligible Expenses per year.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2-10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2-10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
[2.] 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:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] ~~[100% after you pay a Copayment of $[300 - 1,000] per day]~~ ~~[100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]~~	[Yes] [No]	[Yes] [No]
	Air Ambulance: [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] ~~[100% after you pay a Copayment of $[2,500 -~~	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	~~10,000] per day]~~ ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]~~		
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] ~~[100% after you pay a Copayment of $[300 - 1,000] per day]~~ ~~[100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]~~	[Yes] [No]	[Yes] [No]
	Air Ambulance: [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day]~~ ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]~~	[Yes] [No]	[Yes] [No]
[3.] 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.			
	[Designated Network]		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[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*.]		
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.)	***[Network]*** 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.*		
[4.] [Congenital Heart Disease Surgeries]			
[Applies for plan designs that require the use of a designated facility.] **[Prior Authorization Requirement]** [For Covered Health Services required to be ~~performed~~received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not ~~performed~~received at a Designated Facility and performed by a Designated Physician, Benefits will not be paid.]			
[Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule*	[[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
of Benefits.] *[Applies for plan designs that require the use of a designated facility.]* [CHD surgeries must be received at a Designated Facility and performed by a Designated Physician.]	1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
~~[Limited to $[2,000 - 5,000] per year. Benefits are further limited to a maximum of $[500 - 1,500] per tooth.]~~	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]
[6.] Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***[Designated Network]*** [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*.]		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Network] 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 *[Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.]* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.] *[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]* [Benefits for insulin pumps are limited to a single purchase (including repair/replacement) every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* *[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]*		
	[Network] *[Include when both benefits for durable medical equipment and the*		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Outpatient Prescription Drug Rider are sold.] [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[7.] [Durable Medical Equipment]			
[Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [[year] [two - five] [years]] [[12 - 60] months].] [This limit does not apply to wound vacuums[, which are limited to a single purchase (including repair/replacement) every [[year]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[[two - five] years]] [[12 - 60] months]].] [Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every [three years] [36 months]. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.] [Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months]. Speech aid and tracheo-esophageal voice devices are [not] included in the limits stated above.] [You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[8.] Emergency Health Services - Outpatient			
This includes reimbursement for the cost of one annual voluntary HIV screening test performed on the insured while receiving emergency medical services, other than HIV screening,	[[50 - 100]%] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit. [If you are admitted as an inpatient to a Network	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes, after the Per Occurrence Deductible

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
regardless of necessity, per state mandate. This includes reimbursement of the costs of administering such test, all laboratory expenses to analyze the test, and the costs of communicating to the insured the results of the test and any applicable follow-up. This is not subject to any annual or coinsurance deductible or any copayment other than the copayment that the insured would have to pay for the applicable hospital emergency department visit. **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. *Include only when emergent ENRP applies.* [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.]**	Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - ~~650~~700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - ~~650~~700] per visit for the next [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[100 - 700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for a		of $[5 - 700] per visit is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	condition defined as an Emergency; [50 - 100]% after you pay a Copayment of $[50 - ~~650~~700] per visit for a condition that does not meet the definition of an Emergency] [After you pay a Copayment of $[5 - 700] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[9.] [Hearing Aids]			
[Limited to $[500 - 5,000] in Eligible Expenses every [year] [12 months].] [Benefits are [further] limited to a single purchase (including repair/replacement) per hearing impaired ear every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied]
[10.] Home Health Care			
[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [This visit limit does not include	***[Designated Network]*** [[50 - 100]%] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
any service which is billed only for the administration of intravenous infusion.]	Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	Occurrence Deductible of $[5 - 50] per visit is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
[11.] Hospice Care			
	[Designated Network] [[50 - 100]%] ~~[100% after you pay a Copayment of $[5 - 100] per day]~~ ***[Network]*** ~~[~~[50 - 100]%~~]~~ ~~[100% after you pay a Copayment of $[5 - 100] per day]~~	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[12.] Hospital - Inpatient Stay			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Inpatient Stay is satisfied]
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as described below:] • [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
- 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply] [be reduced to $[100 - 1,750].] [The maximum reduction in Copayments is $[10 - 1,000].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750] [The maximum reduction in Copayments is $[10 - 1,000].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] • [Without clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].] [Ventricular assist device implantation services must be received at a Designated Facility.]			
[13]. [Infertility Services]			
[Prior Authorization Requirement] *[Applies for plans that do NOT require the use of a designated facility. When included remove prior authorization option below.]* [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] *[Applies for plans that require the use of a designated facility. When included remove prior authorization option above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, and as a result infertility services are not received at a Designated Facility and performed by a Designated Physician, Benefits will not be paid.]			
[Limited to $[2,000 - 30,000] per	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.] [Benefits for Assisted Reproductive Technology (ART) are limited to [one - three] procedure[s] during the entire period of time a Covered Person is enrolled under the Policy.] *[Applies to plan designs that require the use of a designated facility.]* [Infertility services must be received at a Designated Facility and performed by a Designated Physician.]			
[14.] Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding lab [or in a Physician's	 [Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	office]] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a ~~free-standing~~freestanding lab [or in a Physician's office]]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office]]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a Hospital-based lab]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100]		[Yes, after the Per Occurrence Deductible

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	of $[5 - 100] per service is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
X-Ray and Other Diagnostic Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based diagnostic center]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	remaining Eligible Expense]		
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding	[Yes] [No] [Yes] [No]	[Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
[16.] Mental Health Services			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[Network]		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[17.] Neurobiological Disorders			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
- Autism Spectrum Disorder Services			
	[Designated Network]		
	[Inpatient]	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Outpatient]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 -		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.] ***[Network]*** *Inpatient* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]	[Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *Outpatient* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[18.] [Obesity Surgery]			

[Prior Authorization Requirement]

[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization option below.]

[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]

[Applies for plans that do require use of a designated facility. When included remove prior authorization option above.]

[For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, and as a result obesity surgery is not received at a Designated Facility and performed by a Designated Physician, Benefits will not be paid.]

[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]

[Benefits are limited to $[40,000 - 250,000] during the entire period of time a Covered Person is	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
enrolled for coverage under the Policy.] [Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.] *[Applies for plan designs that require the use of a designated facility.]* [Obesity surgery must be received at a Designated Facility and performed by a Designated Physician.]	[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.] [Ostomy Supplies]			
[Limited to $[500 - 25,000] per year.]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[20.] Pharmaceutical Products - Outpatient			
[The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical 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.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 -	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include only when non-emergent ENRP applies. [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.]** [When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.]	Services from a Specialist Physician] ***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[Include when the enhanced benefits for certain procedures/clinical support is sold.] [When you received certain procedures from a Designated Network Physician, your Benefit will be enhanced as described below:] • [With clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.]	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Without clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			
	[Designated Network] *[Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.]* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]		
	[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year. [50 - 100]% for any subsequent visits in that year.]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we	***[Network]*** *[Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.]* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
provide designation.] **[Enhanced Benefits:]** • [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
[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	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
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 [*and *Manipulative Treatment]*.]]	year.]		
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes][No]	[Yes][No]
	[50 - 90]% for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[[50 - 100]% [after you pay a Copayment of $[5	[Yes][No]	[Yes][No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	- 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]		
	[[50 - 100]% for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes][No]	[Yes][No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes][No]	[Yes][No]
	[50 - 100]% for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
[23.] 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			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
outcomes for you and your baby.			
	[Designated Network] [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].] ***[Network]*** 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].		
[24.] Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests Note: In accordance with state law, no Copayment and/or Coinsurance or deductible applies to services for screening mammography testing or cervical cytological testing, except for services received in connection with a Physician's office visit. In this case, the Copayment and/or Coinsurance described above under Physician's Office Services - Sickness and Injury will apply.	100%	No	No
Breast pumps	100%	No	No
[25.] [Prosthetic Devices]			
[Benefits are limited to a single purchase of each type of prosthetic device every [[year] [[two-five] years]] [[12 - 60] months].] [Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			
	[Designated Network] [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*.] *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
	[Network] 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Limited per year as follows: • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [[10 - 100] visits for any combination of physical therapy, occupational therapy and speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]	year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	90]% for any subsequent visits in that year]		
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	[Designated Network] [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of $[5 - 1,000] per date of service is satisfied]
	[Network] [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office [and	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
[Limited to [40 - 180] days per year.] [Limited to: • [[30 - 180] days per year in a Skilled Nursing Facility.] • [Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Services in an Inpatient Rehabilitation Facility are	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
not subject to an annual limit.]	Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]
[30.] Substance Use Disorder Services			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Outpatient]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] [100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[Network]		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per visit for any subsequent visits in that year.]		
[31.] Surgery - Outpatient			
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [$0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[Include when the enhanced benefits for certain procedures/clinical support is sold.] [When you received certain surgical procedures at a Designated Network Facility, your	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%.[The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [Without clinical support, the Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] [You can determine the specific	service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[Network]		
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] [[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[32.] [Temporomandibular Joint Services]			
	[Designated Network] [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*.]		
~~[Limited to $[1,000 - 20,000] per year.]~~	***[Network]*** [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*.]		
[33.] Therapeutic Treatments - Outpatient			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Designated Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per treatment]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office]]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
[34.] 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.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.] [In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance~~]~~	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
services apply when the Covered Health Service is performed at an Urgent Care Center: • [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*.]]	per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
[36.] [Virtual Visits]			
[Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	[50 - 100%] [100% after you pay a Copayment of [$5 - 25] per visit]	[Yes]	[Yes] [No]
[37.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] every [[12 - 36] months] [year] [2 - 3 years].]	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]		
[38.] [Wigs]			
[Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [12 - 36] months.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Additional Benefits Required By District of Columbia Law			
[39.] Child Health Screenings and Immunizations			
	[Designated Network] 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*.		
	[Network] 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*.		
[40.] Habilitative Services			
Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. • [10-100] visits of speech	***[Designated Network]*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
therapy *Include when combined therapy visit limits apply.* [Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.]	***[Network]*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]

Eligible Expenses

[[1]Include if either Emergent ENRP or Non-Emergent ENRP applies.]

[[2]Include and delete #3 if non-emergent services by non-network physicians at a network facility are paid at less than billed charges (Non-Emergent ENRP applies) and if emergency health services are paid as member hold harmless (Emergent ENRP does not apply).]

[[3]Include and delete #2 if non-network physicians at a network facility and Emergency Health Services are paid at less than billed charges (Emergent and Non-Emergent ENRP applies).]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [[1]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. [[2]For Covered Health Services provided by a non-Network facility based Physician (other than Emergency Health Services or services otherwise arranged by us), 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 as described below.] [[3]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 *Certificate*.

For [Designated Network Benefits and] Network Benefits, Eligible Expenses are based on the following:

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

[[1]Do not include when Emergent ENRP applies.]

- When Covered Health Services are received from a non-Network provider [[1]as a result of an Emergency or] as arranged by us, Eligible Expenses are ~~billed charges unless a lower~~an amount ~~is negotiated or authorized by law~~negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

[Include if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP).]

[**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 - 200]% 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, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance Use Disorder 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.]

Include if Emergency Health Services by non-network physicians or facilities are paid at less than billed charges (Emergent ENRP).

[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 - 200]% 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, 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 and/or a Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses ~~at our discretion~~.

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

You or your Network Physician must notify us of special service needs (such as transplants[, 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.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

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

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

Document comparison by Workshare Compare on Wednesday, November 09, 2016 10:36:12 PM

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Insertion	
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Format change	
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Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	346
Deletions	70
Moved from	0
Moved to	0
Style change	0
Format changed	0
Total changes	416

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all cost sharing to apply to the out-of-pocket maximum, including all cost sharing for Essential Health Benefits. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the out-of-pocket maximum or to remove the out-of-pocket maximum can only be utilized for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Any variables below that allow the cost shares under the outpatient prescription drug rider to not apply to the out-of-pocket maximum may only be utilized for grandfathered plans, or by non-grandfathered plans that include a separate out-of-pocket drug maximum (which when combined with the medical out-of-pocket maximum may not exceed the annual limitation on cost sharing required under ACA).]

[[1]Product name is variable for possible future product name change]

UnitedHealthcare [[1]Non-Differential PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level.

We arrange for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

[[1]Include when shared savings program applies.]

Depending on the geographic area and the service you receive, you may have access [[1]through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [[1]when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under a [UnitedHealthcare] Policy.

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

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

Prior Authorization

We require prior authorization for certain Covered Health Services. Services for which you are required to obtain prior authorization are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. 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.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card.** This call starts the utilization review process.

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

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 and ground.
- [Breast pumps.]
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- [Diabetes equipment - insulin pumps [over $[1,000 - 5,000]].]
- [Durable Medical Equipment [over $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Habilitative Services.]
- [Hearing aids [that exceed $[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- [Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.]
- [Lab, X-ray and major diagnostics - CT, PET ~~Scans~~scans, MRI, MRA, ~~Nuclear Medicine and Capsule Endoscopy~~capsule endoscopy and nuclear medicine, including nuclear cardiology.]
- Mental Health Services - inpatient services (including ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility)~~facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment ~~and services at a Residential Treatment Facility),~~; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*.
- [Obesity surgery.]
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]
- [Prosthetic devices [over $[1,000 - 5,000] in cost per device].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility)~~facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.

[[1]Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

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

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
[Annual deductible is plan design variable. Include applicable provisions to support the following: *[1]Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.* *[2]Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.* *[3]Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [[1]The Annual Deductible 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 Rider*. [[2]Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[3]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] *[Include applicable provisions to support the following:* *[1]Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* *[2]Carry-over provision applies.* *[3]Roll-over provision applies in any circumstance.* *[4]Roll-over provision applies only to groups changing from calendar to policy year. [5]Include when roll-over applies only to the individual deductible.* *[6]Include only when a per occurrence deductible applies.]* [[1]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.] [[2]Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] [[3]When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any	*[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.]

Payment Term And Description	Amounts
amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] [[4]When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [[5]This roll-over feature applies only to the individual 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. [[6]The Annual Deductible does not include any applicable Per Occurrence Deductible.]	
[Per occurrence deductible is plan design variable.] **[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
[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following: *[1]Includes the annual deductible.* *[2]Includes the per occurrence deductible.* *[3]Includes copayments.* *[4]Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]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 Rider*.] *[Include when plan design does not apply all copayments/coinsurance to the OOPM.]* [[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. *[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]* • [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. *[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]* • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	*[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible,

Payment Term And Description	Amounts
	Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No 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.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the ~~Pharmaceutical Product~~Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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*

Payment Term And Description	Amounts
Benefits table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. [For Pharmaceutical Products, your Coinsurance is determined by the tier to which the ~~Pharmaceutical Product~~Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.

- Prior authorization requirements and any penalty for failure to prior authorize

- Any other specific conditions for coverage described within the category.]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - 5,000] in Eligible Expenses per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[2.] 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:* [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	Air Ambulance: [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Non-Emergency Ambulance	*Ground Ambulance:*		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Ground or air ambulance, as we determine appropriate.	[[50 - 100]%] *Air Ambulance:* [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[3.] 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*.	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*.		
[4.] [Congenital Heart Disease Surgeries]			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
~~[Limited to $[2,000 - 5,000] per year. Benefits are further limited~~	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
~~to a maximum of $[500 - 1,500] per tooth.]~~			
[6.] Diabetes Services			

[[1]Include when the durable medical equipment benefit is sold.]

[[2]Include when the durable medical equipment benefit is not sold.]

Prior Authorization Requirement

You must obtain prior authorization before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].

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	*[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]*
Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.	[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.]
[Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.]	*[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]*
	[For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*.
[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]	For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]
[Benefits for insulin pumps are limited to a single purchase (including repair/replacement) every [[year] [[two-five] years]] [[12 - 60] months].]	*[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]*
	[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]
	Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.]
	[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[7.] [Durable Medical Equipment]			
[Prior Authorization Requirement] [You must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [[year] [two - five] [years]] [[12 - 60] months].] [This limit does not apply to wound vacuums[, which are limited to a single purchase (including repair/replacement) every [[year] [[two - five] years]] [[12 - 60] months]].] [Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every [three years] [36 months]. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.] [Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months]. Speech aid and tracheo-esophageal voice	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
devices are [not] included in the limits stated above.]			
[8.] Emergency Health Services - Outpatient			
This includes reimbursement for the cost of one annual voluntary HIV screening test performed on the insured while receiving emergency medical services, other than HIV screening, regardless of necessity, per state mandate. This includes reimbursement of the costs of administering such test, all laboratory expenses to analyze the test, and the costs of communicating to the insured the results of the test and any applicable follow-up. This is not subject to any annual or coinsurance deductible or any copayment other than the copayment that the insured would have to pay for the applicable hospital emergency department visit.	[[50 - 100]%] [After you pay a Copayment of $[5 - 700] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 700] per visit is satisfied]
[9.] [Hearing Aids]			
[Prior Authorization Requirement] [You must obtain prior authorization before obtaining a hearing aid [that exceeds $[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to $[500 - 5,000] in Eligible Expenses every [year] [12 months].] [Benefits are [further] limited to a single purchase (including repair/replacement) per hearing impaired ear every [[year] [[two-five] years]] [[12 - 60] months].]	[[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied]
[10.] Home Health Care			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 -			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
95]% of Eligible Expenses.]			
[Limited to [40 - 200] 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.]	[[50 - 100]%] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
[11.] Hospice Care			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	~~[~~[50 - 100]%~~]~~	[Yes] [No]	[Yes] [No]
[12.] Hospital - Inpatient Stay			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	[[50 - 100]%] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
[13]. [Infertility Services]			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.] [Benefits for Assisted Reproductive Technology (ART) are limited to [one - three] procedure[s] during the entire period of time a Covered Person is enrolled under the Policy.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement] [For sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient:	[[50 - 100]%] [[50 - 100]% at a ~~free-standing~~freestanding lab] [[50 - 100]% at a Hospital-based lab] [[50 - 100]% at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
X-Ray and Other Diagnostic	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Testing - Outpatient:	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
[Prior Authorization Requirement] [~~You~~For CT, PET scans, MRI, MRA, capsule endoscopy, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [[50 - 100]% at a ~~free-standing~~freestanding diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[25 - 850] per service is satisfied]
[16.] Mental Health Services			
Prior Authorization Requirement For a scheduled admission for Mental Health Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible			

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Expenses.			
	Inpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[100% for visits for medication management]		
	[[50-100]% [after you	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[17.] Neurobiological Disorders - Autism Spectrum Disorder Services			
Prior Authorization Requirement For a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	Inpatient [[50 - 100]%] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *Outpatient* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied] [Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[18.] [Obesity Surgery]			
[Prior Authorization Requirement] [You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[In addition, you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[Benefits are limited to $[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.] [Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.]	[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*.] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[19.] [Ostomy Supplies]			
[Limited to $[500 - 25,000] per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[20.] Pharmaceutical Products - Outpatient			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] [You must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical Product is packaged or designed to	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 -	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
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.]	250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Specialist Physician]		
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements. **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit]		
	[100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any	[Yes] [No]	[Yes] [No]

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	subsequent visits in that year.]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[23.] Pregnancy - Maternity Services			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. **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].		

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[24.] Preventive Care Services			
[Include prior authorization requirement if prior authorization requirements apply. Include penalty statement if a penalty is assessed and select the applicable penalty.] **[Prior Authorization Requirement]** [You must obtain prior authorization before obtaining a breast pump. [If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]]			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests Note: In accordance with state law, no Copayment/Coinsurance or deductible applies to services for screening mammography testing or cervical cytological testing, except for services received in connection with a Physician's office visit. In this case, the Coinsurance described above under Physician's Office Services - Sickness and Injury will apply.	100%	No	No
Breast pumps	100%	No	No
[25.] [Prosthetic Devices]			
[Prior Authorization Requirement] [You must obtain prior authorization before obtaining prosthetic devices [that exceed $[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of each type of prosthetic device every [[year] [[two-five] years]] [[12 - 60] months].] [Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Prior Authorization Requirement You must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]			
	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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited per year as follows: • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 - 100] visits for any combination of physical therapy, occupational therapy and speech therapy.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
• [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding center] [[50 - 100]% at an outpatient Hospital-	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per service is satisfied]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	based center] [After you pay a Copayment of $[5 - 1,000] per service at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
[Limited to [40 - 180] days per year.] [Limited to: • [[30 - 180] days per year in a Skilled Nursing Facility.] • [Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.]	[[50 - 100]%] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]
[30.] Substance Use Disorder Services			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Prior Authorization Requirement For a scheduled admission for Substance Use Disorder Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	Inpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment]		
	[After you pay a Copayment of $[5 - 1,000] per session for Partial		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[31.] Surgery - Outpatient			
[[1]Does not apply if prior authorization is required for all pain management.] **[Prior Authorization Requirement]** [For [all outpatient surgeries] [[blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[10 - 1,000] per date of service is satisfied]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	ambulatory surgical center] [[50 - 100]% at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[32.] [Temporomandibular Joint Services]			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.]			
~~[Limited to $[1,000 - 20,000] per year.]~~	[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*.]		
[33.] Therapeutic Treatments - Outpatient			
[Prior Authorization Requirement] [[2]You must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding center] [[50 - 100]% at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		treatment is satisfied]
[34.] 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 fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. [In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.]	[[50 - 100]%	[Yes] [No]	[Yes] [No]
[36.] [Virtual Visits]			
[Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a	[50 - 100%] [100% after you pay a Copayment of [$5 - 25]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	per visit]		
[37.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] every [[12 - 36] months] [year] [2-3 years].]	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]
[38.] [Wigs]			
[Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [12 - 36] months.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
Additional Benefits Required By District of Columbia Law			
[39.] Child Health Screenings and Immunizations			
	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*.		
[40.] Habilitative Services			
Include when notification is required for any habilitative service. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [speech therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. ~~-~~ [10-100] visits of speech	~~[50 - 100%]~~ ~~[100% after you pay a Copayment of $[5 - 150]~~*Include when per* ~~visit]~~*therapy limits apply.* [Limited per year as follows: • [10-100] visits of	*Include when per therapy limits apply.* [~~Yes]~~ ~~[No]~~Limited per year as follows: • [10-100] visits of physical	*Include when per therapy limits apply.* [~~Yes]~~ ~~[No]~~Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy.

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
therapy	physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	[10-100] visits of speech therapy
~~*Include when combined therapy visit limits apply.*~~ ~~[Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.]~~			

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

Eligible Expenses are based on either of the following:

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

[MNRP payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors~~, at our discretion~~.
- If rates have not been negotiated, then one of the following amounts:
  - Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, 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 an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative

value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.

- For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
- When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

- For Mental Health Services and Substance Use Disorder 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.

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

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

[Traditional OON payment option.]

- **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors~~, at our discretion~~.
- If rates have not been negotiated, then one of the following amounts:
  - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - For Mental Health Services and Substance Use Disorder 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.
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
  - When a rate is not published by *CMS* for the service, we use 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.]

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.

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.

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 and/or a Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses~~ at our discretion~~.

Document comparison by Workshare Compare on Wednesday, November 09, 2016 10:41:59 PM

Input:	
Document 1 ID	file://\\nas02082pn\data3\LGL\Esther Drew\Product-Mandate Filings\DC\2017 Filings\Large Group\UHIC\Drafting\2016 Approved\SBN16-Medical-INS-2011-NonDifferential-DC.doc
Description	SBN16-Medical-INS-2011-NonDifferential-DC
Document 2 ID	file://\\nas02082pn\data3\LGL\Esther Drew\Product-Mandate Filings\DC\2017 Filings\Large Group\UHIC\Filing\SBN17-Medical-INS-2011-NonDifferential-LG-DC.doc
Description	SBN17-Medical-INS-2011-NonDifferential-LG-DC
Rendering set	Standard

Legend:	
Insertion	
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Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	111
Deletions	43
Moved from	6
Moved to	6
Style change	0
Format changed	0
Total changes	166

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum, including all cost sharing for Essential Health Benefits. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the network out-of-pocket maximum or to remove the network out-of-pocket maximum can only be utilized for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Any variables below that allow the cost shares under the outpatient prescription drug rider to not apply to the out-of-pocket maximum may only be utilized for grandfathered plans, or by non-grandfathered plans that include a separate out-of-pocket drug maximum (which when combined with the medical out-of-pocket maximum may not exceed the annual limitation on cost sharing required under ACA).]

[[1]Product name is variable for possible future product name change]

UnitedHealthcare [[1]Options PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

You can choose to receive [Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

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

[Select the applicable option(s) and delete the others. *If either Option #1 or #2 is included, you must delete all other options 3, 4, 5 and 6 to support payment methods available prior to Emergent and Non-Emergent ENRP.]*

[[1]Include if non-network RAPLs at a network facility are paid as network benefits.]

[[1]Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[2]Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

[[2]For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.]

[[3]Include and delete #4 if Emergency Health Services provided by a non-Network provider are paid as network benefits, and member hold harmless (Emergent ENRP Option does not apply).]

[[4]Include and delete #3 if Emergency Health Services provided by a non-Network provider are not paid at billed charges (Emergent ENRP Option).]

[[3]Emergency Health Services are always paid as Network Benefits.]

[[4]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.**]

[[5]Include and delete #6 if non-emergent services by non-network RAPLEs at a network facility are paid as network benefits and member hold harmless (Non-Emergent ENRP Option does not apply).]

[[6]Include and delete #5 if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP Option).]

[[5]For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Benefits for non-Emergency Covered Health Services include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[6]Covered Health Services that are provided at a Network facility 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.**]

[[7]Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as *Out-of-Network Benefits.* [[7]Covered Health Services, when not Emergency Health Services, provided in a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant] will be paid as Non-Network Benefits.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Include when the enhanced benefits for certain procedures/clinical support is sold.]

[You may have an opportunity to received enhanced Benefits for certain procedures received at a Designated Facility and/or by a Designated Physician as described in this *Schedule of Benefits*. You can also determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* the telephone number on your ID card.]

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance

will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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

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

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

Prior Authorization

[[1]Include when network providers are responsible for prior authorization for network benefits.]

We require prior authorization for certain Covered Health Services. [[1]In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization.] Services for which you are required to obtain prior authorization are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

[[1]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.]

When you choose to receive certain Covered Health Services [[1]from non-Network providers], you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card.** This call starts the utilization review process.

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

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 and ground.
- [Breast pumps.]
- Clinical trials.

- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- [Diabetes equipment - insulin pumps [over $[1,000 - 5,000]].]
- [Durable Medical Equipment [over $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Habilitative Services.]
- [Hearing aids [that exceed $[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- [Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.]
- [Lab, X-ray and major diagnostics - CT, PET ~~Scans~~scans, MRI, MRA, ~~Nuclear Medicine and Capsule Endoscopy~~capsule endoscopy and nuclear medicine, including nuclear cardiology.]
- Mental Health Services - inpatient services (including ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility)~~facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility),~~facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*.
- [Obesity surgery.]
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]
- [Prosthetic devices [over $[1,000 - 5,000] in cost per device].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].

- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility)~~facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management~~;~~; medication assisted treatment programs for substance use disorder.

[[1]Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[[1]Include when network providers are responsible for prior authorization for network benefits.]

For all other services, [[1]when you choose to receive services from non-Network providers], we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
[Annual deductible is plan design variable. Include applicable provisions to support the following: *[1]Annual deductible applies only to non-network benefits.* *[2]Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.* *[3]Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.* *[4]Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.* *[5]Outpatient Prescription Drug Rider is sold, there is a deductible for designated and/or network benefits and the network and non-network amounts apply to the designated network and/or network annual deductible.* *[6]Include when Designated Network Benefits apply to any benefit category]* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [[1]Non-Network] Benefits. [[2]The Annual Deductible 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 Rider*. [[3]Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[4]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] [[5]The Annual Deductible for [[6]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the *Outpatient Prescription Drug Rider*.] *[Include applicable provisions to support the following:* *[1]Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* *[2]Carry-over provision applies.* *[3]Roll-over provision applies in any circumstance.* *[4]Roll-over provision applies only to groups changing from calendar to policy year. [5]Include when roll-over applies only to the individual deductible.*	*[[1]Include separate network and non-network headings and statements when annual deductible provision applies separately.]* *[[2]Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]* *[[3]Include when designated network and network are separate.]* ***[[1][[2]Designated Network and] Network] [[3]Designated Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[[3]Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible

Payment Term And Description	Amounts
[6Include only when a per occurrence deductible applies.] [1Amounts 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.] [2Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] [3When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] [4When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [5This roll-over feature applies only to the individual 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. [6The Annual Deductible does not include any applicable Per Occurrence Deductible.] *[Applies when cross accumulation applies to Designated Network and Network Annual Deductible.]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.]	is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[1Non-Network]*** *[A Non-embedded.]* *[B Embedded.]* [A For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] *[4Include the combined network and non-network heading and statements when annual deductible provision applies separately to combined network and non-network benefits.* *5Include when designated network benefits apply to any category.]* ***[4[5Designated Network,] Network and Non-Network]*** *[A Non-embedded.]* *[B Embedded.]* [A For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single

Payment Term And Description	Amounts
	coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
[Per occurrence deductible is plan design variable.] **[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	
[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following: *[1]Includes the annual deductible.* *[2]Includes the per occurrence deductible.* *[3]Includes copayments.* *[4]Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.* *[5]Outpatient Prescription Drug Rider is sold, the OOPM applies to designated and/or network benefits and the network and non-network amounts paid under the RX rider apply to the designated network and/or network OOPM.* *[6]Include when Designated Network Benefits apply to any benefit category]* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]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 Rider*.] [[5]The	*[[1]Include separate network and non-network headings and statements when OOPM provision applies separately.]* *[[2]Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]* *[[3]Include when designated network and network are separate.]* ***[[1][[2]Designated Network and] Network] [[3]Designated Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket

Payment Term And Description	Amounts
Out-of-Pocket Maximum for [[6]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.] *[Include when plan design does not apply all copayments/coinsurance to the OOPM.]* [[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. *[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]* • [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. *[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]* • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] *[Applies when cross accumulation applies to Designated Network and Network OOPM]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Out-of-Pocket Maximum will be applied to the Network Out-of-Pocket Maximum. Any amount you pay for Covered Health Services that is applied to the Network Out-of-Pocket Maximum will be applied to the Designated Network Out-of-Pocket Maximum.]	Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 -

Payment Term And Description	Amounts
	45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[3]Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.*

Payment Term And Description	Amounts
	[B] *Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your

Payment Term And Description	Amounts
	Outpatient Prescription Drug Schedule of Benefits] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[1]Non-Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]~~ per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] *[[4]Include combined network and non-network heading and statements below*

Payment Term And Description	Amounts
	when OOPM provision applies to combined network and non-network benefits and delete the separate "Network" and "Non-Network" provisions above.] *[5Include when designated network benefits apply to any category.]* ***[A[5Designated Network,] Network and Non-Network]*** *A Non-embedded.* *B Embedded.* [A For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [B $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No 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.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the ~~Pharmaceutical Product~~Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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

- The applicable Copayment.

Payment Term And Description	Amounts
• 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. [For Pharmaceutical Products, your Coinsurance is determined by the tier to which the ~~Pharmaceutical Product~~Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.

- Prior authorization requirements and any penalty for failure to prior authorize

- Designated network benefit levels as applicable.

- Any other specific conditions for coverage described within the category.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
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. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - 5,000] in Eligible Expenses per year.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance]
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
[2.] 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	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] ~~[100% after you pay a Copayment of $[300 - 1,000] per day]~~ ~~[100% after you pay a~~	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	~~Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]~~ *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day]~~ ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]~~ ***Non-Network*** Same as Network	[Yes] [No] Same as Network	[Yes] [No] Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] ~~[100% after you pay a Copayment of $[300 - 1,000] per day]~~ ~~[100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]~~ *Air Ambulance:* [[50 - 100]%] [100% after you pay a	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[25 - 2,500] per transport] ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day]~~ ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]~~ ***Non-Network*** *Ground Ambulance:* [[50 - 100]%] [Same as Network] *Air Ambulance:* [[50 - 100]%] [Same as Network]	[Yes][No] [Same as Network]	[Yes][No] [Same as Network]
[3.] 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.			
	[Designated Network] [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.*]		
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	***Network*** 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.* ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Health Service category in this *Schedule of Benefits.*		
[4.] [Congenital Heart Disease Surgeries]			
[Prior Authorization Requirement] *[Applies for plan designs that do NOT require the use of a designated facility. When included, remove prior authorization requirements below.]* [For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] *[Applies for plan designs that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included remove the prior authorization requirement above.]* [For Covered Health Services required to be ~~performed~~received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not ~~performed~~received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid.] [[2]Network Benefits will apply] *[[3]Include when network providers are responsible for prior authorization for network benefits. [4]Include when covered person is responsible for prior authorization for network benefits.]* [[[3]For Non-Network Benefits you] [[4]You] must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Designated Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
stated under each Covered Health Service category in this *Schedule of Benefits*.] [Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[[1]Applies for plan designs that include Network Benefits only and require the use of designated facility. [[1]For Network Benefits, CHD surgeries must be received at a Designated Facility and performed by a Designated Physician.] *[[1]Applies for plan designs that include designated network and non-network benefits.]* [[1]For Designated Network Benefits, CHD surgeries must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services ~~provided~~received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician.	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Non-Network Benefits under this section include only the CHD surgery] *[Applies for plan designs that require the use of a designated facility]* [Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]	Expense]		
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement] [For [Designated Network,] Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]
~~[Limited to $[2,000 - 5,000] per year. Benefits are further limited to a maximum of $[500 - 1,500] per tooth.]~~	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] ***[Non-Network]*** [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Same as Network]
[6.] Diabetes Services			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* *[[3]Include when the durable medical equipment benefit is sold.]* *[[4]Include when the durable medical equipment benefit is not sold.]* [[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization before obtaining any [[3]Durable Medical Equipment] [[4]diabetes equipment] for the management and treatment of diabetes [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].			
Diabetes Self-Management and	***[Designated Network]***		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
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 and Training/Diabetic Eye Examinations/Foot Care**~~	***Network*** 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*. ***Non-Network*** 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 *Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.] *[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]* [Benefits for insulin pumps are limited to a single purchase (including repair/replacement) every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.] [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***~~Non-~~Network*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		

When Benefit limits apply, the limit refers to any combination of ***[Designated Network Benefits,]*** *Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[7.] [Durable Medical Equipment]			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Prior Authorization Requirement]			
[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]			
[[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [[year] [two - five] [years]] [[12 - 60] months].] [This limit does not apply to wound vacuums[, which are limited to a single purchase (including repair/replacement) every [[year] [[two - five] years]] [[12 - 60] months]].] [Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every [three years] [36 months]. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.] [Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months]. Speech aid and tracheo-esophageal voice devices are	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[not] included in the limits stated above.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[8.] Emergency Health Services - Outpatient			
This includes reimbursement for the cost of one annual voluntary HIV screening test performed on the insured while receiving emergency medical services, other than HIV screening, regardless of necessity, per state mandate. This includes reimbursement of the costs of administering such test, all laboratory expenses to analyze the test, and the costs of communicating to the insured the results of the test and any applicable follow-up. This is not subject to any annual or coinsurance deductible or any copayment other than the copayment that the insured would have to pay for the applicable hospital emergency department visit. **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	***Network*** [[50 - 100]%] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit. [If you are admitted as an inpatient to a Network Hospital directly from the Emergency room you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes, after the Per Occurrence Deductible of $[5 - 700] per visit is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. *Include only when emergent ENRP applies.* [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.**]	you pay a Copayment of $[50 - ~~650~~700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - ~~650~~700] per visit for the next [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[100 - 700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for a condition defined as an Emergency; [50 - 100]% after you pay a Copayment of $[50 - ~~650~~700] per visit for a condition that does not meet the definition of an Emergency] [After you pay a Copayment of $[5 - 700] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** Same as Network	Same as Network	Same as Network
[9.] [Hearing Aids]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include*			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
when covered person is responsible for prior authorization for network benefits.]			
[[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization before obtaining a hearing aid [that exceeds $[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to $[500 - 5,000] in Eligible Expenses every [year] [12 months].] [Benefits are [further] limited to a single purchase (including repair/replacement) per hearing impaired ear every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]***		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied]
	[Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied]
	[Non-Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied]
[10.] Home Health Care			
[Prior Authorization Requirement]			
[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
when covered person is responsible for prior authorization for network benefits.]			
[[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] 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.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense]		
[11.] Hospice Care			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, [[1]for Non-Network Benefits,] you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	[Designated Network] [[50 - 100]%] ~~[100% after you pay a Copayment of $[5 - 100] per day]~~ ***Network*** ~~[~~[50 - 100]%~~]~~ ~~[100% after you pay a Copayment of $[5 - 100] per day]~~ ***Non-Network*** ~~[~~[50 - 100]%~~]~~ ~~[100% after you pay a Copayment of $[5 - 100] per day]~~	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[12.] Hospital - Inpatient Stay			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[1]For Non-Network Benefits for] [[2]For] a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as described below:] • [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply] [be reduced to $[100 - 1,750].] [The maximum reduction in Copayments is $[10 - 1,000].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000].	Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750] [The maximum reduction in Copayments is $[10 - 1,000].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] • [Without clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].] [[For Network Benefits, ventricular] [Ventricular] assist device implantation services must be received at a Designated Facility.]	***Non-Network*** [[50 - 100]%] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
[13]. [Infertility Services]			
[Prior Authorization Requirement] *[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization options below.]* [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] *[Required for plans that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included, remove prior authorization option above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, and as a result infertility services are not received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid][[2]Network Benefits will apply.] [[2]For [Network and] Non-Network Benefits, you must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50-90]% of Eligible Expenses][you will be responsible for paying all charges and no Benefit will be paid.]			
	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.] [Benefits for Assisted Reproductive Technology (ART) are limited to [one - three] procedure[s] during the entire period of time a Covered Person is enrolled under the Policy.] *[[1]Applies to plan designs with Network Benefits only that require the use of designated facility.]* [[1]For Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician.] *[[1]Applies for plan designs that include designated network and non-network benefits]* [[1]For Designated Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services ~~provided~~received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits for] [[2]For] sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of $[5 - 100] per service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the remaining Eligible Expense] [[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
X-Ray and Other Diagnostic Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits ~~you] [[2]You]~~for] [[2]For] CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
[16.] Mental Health Services			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[1]For Non-Network Benefits for] [[2]For] a scheduled admission for Mental Health Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, [[1]for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network]		
	[Inpatient]	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Outpatient]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.] ***Network*** *Inpatient* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a	[Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *Outpatient*		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management] [[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
	Non-Network *Inpatient* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *Outpatient* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[17.] Neurobiological Disorders - Autism Spectrum Disorder Services			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[1]For Non-Network Benefits for] [[2]For] a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, [[1]for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management~~[~~; Intensive Behavioral Therapy, including *Applied Behavioral Analysis~~]~~ (ABA)*. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]*		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	~~Non-~~Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 -		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[18.] [Obesity Surgery]			

[Prior Authorization Requirement]

[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization options below.]

[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]%

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[Required for plans that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included, remove prior authorization option above.] [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, and as a result obesity surgery is not received at a Designated Facility and performed by Designated Physician, [[1]Benefits will not be paid][[2]Network Benefits will apply] [[2]For [Network and] Non-Network Benefits, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required [Benefits will be reduced to [50-95]% of Eligible Expenses][you will be responsible for paying all charges and no Benefits will be paid.] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[[Any combination of] [Designated Network Benefits] [[,] [and] [Network Benefits] [and Non-Network] Benefits [is] [are] limited to $[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. [Non-Network Benefits are further limited to $[5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]] [Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[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*.]		
[Applies for plan designs with Network Benefits only that require the use of a designated facility.] [For Network Benefits, obesity surgery must be received at a Designated Facility and performed by Designated Physician.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[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*.]		
[Applies for plan designs that include designated network and non-network benefits.] [For Designated Network Benefits, obesity surgery must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services ~~provided~~received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician.]	***[Non-Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[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.] [Ostomy Supplies]			
[Limited to $[500 - 25,000] per year.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[20.] Pharmaceutical Products - Outpatient			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical 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.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product]	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 -	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[Designated Network] [[50 - 100]%]	 [Yes] [No]	 [Yes] [No]
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
Include only when non-emergent	***Network***		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
ENRP applies. [Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses 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.**] [When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures from a Designated Network Physician, your Benefit will be enhanced as described below:] • [With clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] • [Without clinical support, the Coinsurance you pay			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.]			
[You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
Neither option below will be included with Non-Emergent ENRP.	***Non-Network***		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]			
[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year. [50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.]	***Network*** *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Enhanced Benefits:] • [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.		
	[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year. [50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[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	***Non-Network*** *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
procedures described under *Therapeutic Treatments - Outpatient*.] • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [*and *Manipulative Treatment]*.]]	10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Primary Physician office visit for the first [2 - 10] visits in a year.]		
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[23.] Pregnancy - Maternity Services			
Prior Authorization Requirement			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
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]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]			
[[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. **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.**			
	[Designated Network] [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].]		
	Network 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]. ***Non-Network*** 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].		
[24.] Preventive Care Services			
[Include prior authorization requirement if prior authorization requirements apply. Include penalty statement if a penalty is assessed and select the applicable penalty.]			
[Prior Authorization Requirement] [For Non-Network Benefits, you must obtain prior authorization before obtaining a breast pump. [If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]]			
Physician office services	***Network*** 100% ***Non-Network***	No	No

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% for immunizations when no other service is provided during the office visit.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
Lab, X-ray or other preventive tests	***Network*** 100%	No	No
~~**Lab, X-ray or other preventive tests**~~ **Note:** In accordance with state law, for Network Benefits no Copayment and/or Coinsurance or deductible applies to services	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
for screening mammography testing or cervical cytological testing, except for services received in connection with a Physician's office visit. In this case, the Copayment and/or Coinsurance described above under *Physician's Office Services - Sickness and Injury* will apply.	per service]		
	~~***Non-Network***~~ ~~[[50 - 100]%]~~ ~~[100% after you pay a Copayment of $[5 - 100] per service]~~	~~[Yes] [No]~~	~~[Yes] [No]~~
Breast pumps	***Network*** 100% ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100]]	No [Yes] [No]	No [Yes] [No]
[25.] [Prosthetic Devices]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization before obtaining prosthetic devices [that exceed $[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of each type of prosthetic device every [[year] [[two-five] years]] [[12 - 60] months].] [Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of*	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1998.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[26.] Reconstructive Procedures			

Prior Authorization Requirement

[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]

[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].

[In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]

	[Designated Network] [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*.] *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]
	Network 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]*

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited per year as follows: • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 - 100] visits for any	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
combination of physical therapy, occupational therapy and speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]]	Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]		
[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.] [Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.] [Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation	***[~~Non-~~Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]			
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100]% of the remaining Eligible Expense]		
	Network	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[After you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per date of		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Non-Network		
	[[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits for] [[2]For] a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
[Limited to [40 - 180] days per year.] [Limited to: • [[30 - 180] days per year in a Skilled Nursing Facility.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.] [Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]	[100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		satisfied]
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		[Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]
[30.] Substance Use Disorder Services			

Prior Authorization Requirement

[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]

[[1]For Non-Network Benefits for] [[2]For] a scheduled admission for Substance Use Disorder Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, [[1]for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.

If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Designated Network]		
	[Inpatient]	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Outpatient]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
	~~Non-~~Network *Inpatient* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *Outpatient*		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] *Outpatient*		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[31.] Surgery - Outpatient			
[[1]Does not apply if prior authorization is required for all pain management.] **[Prior Authorization Requirement]** *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits for] [[2]For] [all outpatient surgeries] [[blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [$0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
applicable deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[Include when the enhanced benefits for certain procedures/clinical support is sold.] [When you received certain surgical procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [With clinical support, the	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%.[The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [Without clinical support, the Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Network		
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year]		
	[After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an ambulatory surgical center or in a Physician's office]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 -		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[32.] [Temporomandibular Joint Services]			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled inpatient admissions.]			
	[Designated Network] [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*.]		
~~[Limited to $[1,000 - 20,000] per year.]~~	***[Network]*** [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*.] ***[Non-Network]*** [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*.]		
[33.] Therapeutic Treatments - Outpatient			
[Prior Authorization Requirement] *[[1]Include when network providers are responsible for prior authorization for network benefits. [2]Include when covered person is responsible for prior authorization for network benefits.]* [[[1]For Non-Network Benefits you] [[2]You] must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of $[5 - 1,000] per treatment is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	Occurrence Deductible of $[5 - 1,000] per treatment is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
[34.] Transplantation Services			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [Non-Network Benefits will apply.] [For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] *[[1]Include when network providers are responsible for prior authorization for network benefits.]* [In addition, [[1]for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	***Network*** 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.* ***Non-Network*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.] [In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • [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*	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
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*.]]	per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance]
	[100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year]		
	[100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	[100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
[36.] [Virtual Visits]			
~~[~~ Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.~~]~~	***[Network]*** [50 - 100%] [100% after you pay a Copayment of [$5 - 25] per visit] ***[Non-Network]*** [[50 - 100]%]	[Yes] [Yes] [No]	[Yes] [No] [Yes] [No]
[37.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams]	***[Network]***		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
every [[12 - 36] months] [year] [2-3 years].]	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]		
[38.] [Wigs]			
[Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [12 - 36] months.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Additional Benefits Required By District of Columbia Law			
[39.] Child Health Screenings and Immunizations			
	[Designated Network] 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*. ***Network*** 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*.		
	~~***Network***~~ ~~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*.~~ ***Non-Network***		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	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*.		
[40.] Habilitative Services			
Include when notification is required for any habilitative service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [speech therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. ~~•~~ [10-100] visits of speech therapy	~~***[Designated Network]***~~ ~~[50 - 100%]~~ ~~[100% after you pay a Copayment of $[5 - 150]~~*Include when per* ~~visit]~~*therapy limits apply.* [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	*Include when per therapy limits apply.* ~~[Yes]~~ ~~[No]~~[Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy	*Include when per therapy limits apply.* ~~[Yes]~~ ~~[No]~~[Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. [10-100] visits of speech therapy
Include when combined therapy visit limits apply. [Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.]	~~***Network***~~*Include when combined therapy visit limits apply.* ~~[50 - 100%]~~ ~~[100% after you pay a~~	*Include when combined therapy visit limits apply.* ~~[Yes]~~ ~~[No]~~[Any	*Include when combined therapy visit limits apply.* ~~[Yes]~~ ~~[No]~~[Any combination of

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	~~Copayment~~[Any combination of ~~$[5 - 150] per visit]~~outpatient habilitative services is limited to [10 - 160] visits per year.]	combination of outpatient habilitative services is limited to [10 - 160] visits per year.]	outpatient habilitative services is limited to [10 - 160] visits per year.]
Include when combined therapy visit limits apply separately to network benefits and to non-network benefits. [Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]	*Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* [Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network ~~[50 - 100%]~~ ~~[100% after you pay a Copayment of $[5 - 150] per visit]~~ Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]	*Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* ~~[Yes]~~ ~~[No]~~[Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]	*Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* ~~[Yes]~~ ~~[No]~~[Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]

Eligible Expenses

[1Include if either Emergent ENRP or Non-Emergent ENRP applies or if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

[2Include if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

[[3]Include and delete #4 if non-emergent services by non-network physicians at a network facility are paid at less than billed charges (Non-Emergent ENRP applies) and if emergency health services are paid as member hold harmless (Emergent ENRP does not apply).]

[[4]Include and delete #3 if non-network physicians at a network facility and Emergency Health Services are paid at less than billed charges (Emergent and Non-Emergent ENRP applies).]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [[1]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. [[2]For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by us), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below.] [[3]For Covered Health Services provided by a non-Network facility based Physician (other than Emergency Health Services or services otherwise arranged by us), 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 as described below.] [[4]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.] For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For [Designated Network Benefits and] Network Benefits, Eligible Expenses are based on the following:

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

[[1]Do not include when Emergent ENRP applies.]

- When Covered Health Services are received from a non-Network provider [[1]as a result of an Emergency or] as arranged by us, Eligible Expenses are ~~billed charges unless a lower~~an amount ~~is negotiated or authorized by law~~negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[MNRP payment option.]

  - **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors~~, at our discretion~~.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, 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 an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
  - When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- For Mental Health Services and Substance Use Disorder 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.

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

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

[Include if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP).]

[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 [110-200]% 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, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance Use Disorder 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.**]**

[Include if Emergency Health Services by non-network physicians or facilities are paid at less than billed charges (Emergent ENRP).]

[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.
- [110-200]% 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, 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.**]**

[Traditional OON payment option.]

- **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors~~, at our discretion~~.
- If rates have not been negotiated, then one of the following amounts:
  - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - For Mental Health Services and Substance Use Disorder 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.
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for*

Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

- When a rate is not published by *CMS* for the service, we use 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.]

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

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

Provider Network

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

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

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

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

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

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

Designated Facilities and Other Providers

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

In both cases, Network 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, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

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

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

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Rendering set	Standard

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Insertion	
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Moved cell	
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Padding cell	

Statistics:	
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Insertions	493
Deletions	149
Moved from	6
Moved to	6
Style change	0
Format changed	0
Total changes	654

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum. For non-grandfathered plans that include a separate out-of-pocket drug maximum and/or separate specialty out-of-pocket drug maximum, any combination of the out-of-pocket drug maximum and the specialty drug product out-of-pocket maximum variables and the medical out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the medical out-of-pocket maximum can only be utilized for plans that include a separate medical and prescription drug out-of-pocket maximum or for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans.]

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-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.

[Applies to plan designs that include closed-panel benefits. (Closed panel means that we pay only for drugs that are prescribed by a network provider.)]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

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

[Applies when plan design includes open benefit design.]

[[1]Ancillary charge references here and throughout the schedule apply when plan design includes the mandatory or restrictive program.]

[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 [[1]and an Ancillary Charge may apply]. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.]

[Applies when plan design includes closed benefit design.]

[[1]Applies when plan design includes the mandatory or restrictive program.]

[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 [[1]and an Ancillary Charge may apply,] or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.]

[Applies when plan design includes closed-panel benefits.]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

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.

[Variable references here and throughout are used to support either notification or prior authorization requirements.]

[Notification] [Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [notify] [obtain prior authorization from] us or our designee. The reason for [notifying] [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 [notify] [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 [Notification] [Prior Authorization]

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

Non-Network Pharmacy [Notification] [Prior Authorization]

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for [notifying] [obtaining prior authorization from] us as required.

If [we are not notified] [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 [notification] [prior authorization] are subject to our periodic review and modification. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may determine whether a particular Prescription Drug Product requires [notification] [prior authorization] through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If [we are not notified] [you do not obtain prior authorization from us] before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

[Therapeutic class charge and therapeutically equivalent charge (here and throughout) is variable by plan design.]

When you submit a claim on this basis, you may pay more because you did not [notify] [obtain prior authorization from] us before the Prescription Drug Product was dispensed. The amount you are

reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance [, Ancillary Charge] [, Therapeutic Class Charge] [, Therapeutically Equivalent 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 [notification] [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 [notification] [prior authorization], participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

[Step Therapy]

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

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

What You Must Pay

[The following bracketed provisions are variable based upon plan design.]

[You are responsible for paying the [Annual Drug Deductible] [and] [Specialty Prescription Drug Product Annual Deductible].]

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

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

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

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

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

[Benefits for [insulin] [or] [diabetic supplies] 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] [[, in addition to any] [or] Therapeutic Class Charge] [[, in addition to any] [or] Therapeutically Equivalent Charge]. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

[[1]Applies when the plan design includes the mandatory generic program.]

[An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your [[1]or the provider's] request and there is another drug that is ~~c~~Chemically Equivalent ~~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 [lower tiered drug] [higher tier drug]~~. [An Ancillary Charge does not apply to any [Annual Drug Deductible] [,] [Annual Deductible] [,] [Specialty Prescription Drug Product Annual Deductible] [,] [or] [Out-of-Pocket Drug Maximum] [,] [or] [Out-of-Pocket Maximum] [or] [Specialty Prescription Drug Product Out-of-Pocket Maximum].]]

[A Therapeutic Class Charge may apply when the Prescription Drug Charge or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

[A Therapeutically Equivalent Charge may apply when the Prescription Drug Charge or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutically Equivalent Charge and any applicable Copayment and/or Coinsurance.]

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

- [Copayments for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Coinsurance for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Ancillary Charges.]
- [Therapeutic Class Charges.]
- [Therapeutically Equivalent Charges.]
- [The Annual Drug Deductible.]
- [The Specialty Prescription Drug Product Annual Deductible.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.]
- [Certain coupons or offers from pharmaceutical manufacturers. 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.]
- 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 following provisions are plan design variable.]

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

[The Specialty Prescription Drug Product Annual Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Out-of-Pocket Drug Maximums are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

[The Infertility Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Payment Term And Description	Amounts
[Annual Drug Deductible]	
[Annual drug deductible is plan design variable.] *[Option 1: Applies when the annual drug deductible is determined based on network or non-network status.]* [The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.] *[Option 2: Applies when the annual drug deductible is determined based on tier status.]* [The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.] [Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.] [Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.] [Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of	*[The variables below correspond with Option 1.]* ***[Network]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Non-Network]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Network and Non-Network]*** [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] *[The variables below correspond with Option 2.]* ***[Tier 1]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 2]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]

Payment Term And Description	Amounts
the Annual Drug Deductible.] *[[1]Applies when only the individual portion is subject to the annual drug deductible.]* [Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [[1]This carry-over feature applies only to the individual Annual Drug Deductible.]] [When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.] *[Applies when the roll-over provision applies to a group changing from a calendar year to policy year plan.]* *[[1]Applies when only the individual portion is subject to the annual drug deductible.]* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual 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 3]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 4]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 5]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 6]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5] [and] [6]]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[Specialty Prescription Drug Product	

Payment Term And Description	Amounts
Annual Deductible]	
[Specialty annual deductible is plan design variable.] *[Option 1: Applies when the specialty annual deductible is determined based on either specialty prescription drug product, per specialty drug product, per therapeutic class and/or growth hormone therapy.]* [The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.] *[Option 2: Applies when the specialty annual deductible is determined based on tier status.]* [The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.] *[[1]Applies when only the individual portion of the specialty prescription drug product annual deductible is subject to the carry-over feature.]* [Any amount you pay that is applied to the Specialty Prescription Drug Product Annual Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current year's Specialty Prescription Drug Product Annual Deductible. [[1]This carry-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]] [When a Covered Person was previously covered under a group policy that was replaced by the group Policy,	*[The variable provisions below correspond with Option 1.]* ***[Specialty Prescription Drug Product]*** *[Include when individual specialty prescription drug product deductible applies.]* [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products.] [This does not include any deductible stated below.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [This does not include any deductible stated below.] ***[Specialty - Per Specialty Prescription Drug Product]*** [$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any deductible stated below.] [$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person, not to exceed $[200 - 3,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any deductible stated below.] ***[Specialty - Growth Hormone Therapy]*** [$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] [$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[200 - 3,000] for growth hormone therapy for all Covered Persons in a family.] ***[Specialty - Per Therapeutic Class]*** [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class A.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class B.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for

Payment Term And Description	Amounts
any amount already applied to that specialty prescription drug product annual deductible provision of the prior policy will apply to the Specialty Prescription Drug Product Annual Deductible provision under the Policy.] *[[1]Applies when only the individual portion of the specialty prescription drug product annual deductible is subject to the roll-over provision for groups changing from a calendar year to policy year plan.]* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Specialty Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Specialty Prescription Drug Product Annual Deductible, will be rolled over and applied to the current Policy year Specialty Prescription Drug Product Annual Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]] [The Specialty Prescription Drug Product Annual Deductible is included in the overall Annual Drug Deductible stated above.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Annual 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.]	Therapeutic Class C.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C, not to exceed $[200 - 3,000] for all Covered Persons in a family.] *[The variable provisions below correspond with Option 2.]* ***[Tier 1]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 2]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 3]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 4]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 5]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 6]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5]***

Payment Term And Description	Amounts
	[and] [6]] [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[Out-of-Pocket Drug Maximum]	
[Out-of-pocket drug maximum is plan design variable. Include applicable provisions to support the following:] *[[1]The out-of-pocket drug maximum applies annually.]* *[[2]The annual out-of-pocket drug maximum includes copayments.]* *[[3]The annual out-of-pocket drug maximum does not include copayments.]* *[[4]The out-of-pocket drug maximum applies monthly.]* *[[5]The monthly out-of-pocket drug maximum includes copayments.]* *[[6]The monthly out-of-pocket drug maximum does not include copayments.]* [[1]The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [[2]Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [[3]The Out-of-Pocket Drug Maximum does not include Copayments.]] [[4]The maximum amount you are required to pay for covered Prescription Drug Products in a single calendar month. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [[5]Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the calendar month. [[6]The Out-of-Pocket Drug Maximum does not include Copayments.]] [Copayments and Coinsurance for	*[Insert maximum amounts according to benefit design chosen by group.]* *[[1]Include if copayments and coinsurance are not subject to an out-of-pocket drug maximum.]* *[[2]Include if copayments and/or coinsurance are subject to an out-of-pocket drug maximum and the benefit design includes an annual drug deductible.]* *[[3]If an annual drug deductible applies, select the appropriate statement about whether or not the annual drug deductible applies to the out-of-pocket drug maximum.]* ***[Network]*** *[Include when individual out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person.] *[Include when individual (with family maximum) out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] ***[Non-Network]*** *[Include when individual out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person.] *[Include when individual (with family maximum) out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] *[Include when there is no out-of-pocket drug maximum for non-network benefits.]*

Payment Term And Description	Amounts
covered Specialty Prescription Drug Products are not limited by the Out-of-Pocket Drug Maximum.] [Copayments and Coinsurance for covered Prescription Drug Products for Infertility are not limited by the Out-of-Pocket Drug Maximum.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Out-of-Pocket Drug Maximum. 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.]	[No Out-of-Pocket Drug Maximum] ***[Network and Non-Network]*** *[Include when individual out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person.] *[Include when individual (with family maximum) out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.]
[Specialty Prescription Drug Product Out-of-Pocket Maximum]	
[Specialty out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:] *[[1]The specialty out-of-pocket drug maximum applies annually.]* *[[2]The specialty annual out-of-pocket drug maximum includes copayments.]* *[[3]The specialty annual out-of-pocket drug maximum does not include copayments.]* *[[4]The specialty out-of-pocket drug maximum applies monthly.]* *[[5]The specialty monthly out-of-pocket drug maximum includes copayments.]* *[[6]The specialty monthly out-of-pocket drug maximum does not include copayments.]* [[1]The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [[2]Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the year. [[3]The Specialty Prescription Drug Product Out-of-Pocket Maximum does	***[Specialty Prescription Drug Product]*** *[Include when individual specialty out-of-pocket maximum applies.]* [$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person.] [This does not include any maximum stated below.] *[Include when individual (with family maximum) specialty out-of-pocket maximum applies.]* [$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [This does not include any maximum stated below.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] ***[Specialty - Per Specialty Prescription Drug Product]*** [$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any maximum stated below.] [$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person, not to exceed $[1,000 - 30,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any maximum stated below.] [This Specialty Prescription Drug Product Out-of-Pocket

Payment Term And Description	Amounts
not include Copayments.]] [[4]The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single calendar month. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [[5]Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the calendar month. [[6]The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]] [Copayments and Coinsurance for covered Specialty Prescription Drug Products for Infertility are not limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Out-of-Pocket Maximum. 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.]	Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] ***[Specialty - Growth Hormone Therapy]*** [$[500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[1,000 - 30,000] for growth hormone therapy for all Covered Persons in a family.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] ***[Specialty - per Therapeutic Class]*** [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket

Payment Term And Description	Amounts
	Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]
[Infertility Annual Maximum Benefit]	
[Applicability of infertility annual maximum drug benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.]	[$[250 - 10,000] per Covered Person.]
[Infertility Maximum Policy Benefit]	
[Applicability of infertility maximum policy benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.]	[$[250 - 10,000] per Covered Person.]
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network or non-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. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate. *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. *[Include when regimen pricing applies to therapeutic treatments.]* [We may cover multiple Prescription Drug Products for a single Copayment	*[[1]Applies when our negotiated rate does not apply.]* *[[2]Applies when our negotiated rate applies.]* For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the [[1]lower] [[2]lowest] of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • [[2]The Prescription Drug Charge for that Prescription Drug Product.] [For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product.] See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

Payment Term And Description	Amounts
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 [notification] [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. *[Include when Copayment/Coinsurance Waiver Program applies.]* [**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.]	

Payment Term And Description	Amounts
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. **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)
[The specialty prescription drug product benefit description is plan design variable.] **[Specialty Prescription Drug Products]**	
[The following supply limits apply. • As written by the provider, up to a consecutive ~~[~~31~~] [60]~~-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive ~~[~~31~~]~~-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[Applies when smart fill program applies]* [If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.] Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [,] [or] a non-Network Pharmacy [,] [or] [a mail order Network Pharmacy] [or] [a Designated Pharmacy].]	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments/coinsurance for growth hormone therapy; differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] ***[Network Pharmacy]*** [For a Tier 1 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[0-75]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]]

Description and Supply Limits	Benefit (The Amount We Pay)
	[For a Tier 2 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[15-250]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[20-450]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[25-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[25-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[25-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than

Description and Supply Limits	Benefit (The Amount We Pay)
	$[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[70-650]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[80-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[80-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[80-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[100-750]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[125-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[125-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[125-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you

Description and Supply Limits	Benefit (The Amount We Pay)
	will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[150-850]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[175-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[175-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] ***[Non-Network Pharmacy]*** [For a Tier 1 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[0-75]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Specialty Prescription Drug Product on the List of

Description and Supply Limits	Benefit (The Amount We Pay)
	Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[15-250]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[3][50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[20-450]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[25-450]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[25-450]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[25-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-

Description and Supply Limits	Benefit (The Amount We Pay)
	225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[70-650]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[80-650]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[80-650]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[80-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[100-750]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[125-750]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[125-750]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[125-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[150-850]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[175-850]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[175-850]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Specialty Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the*

Description and Supply Limits	Benefit (The Amount We Pay)
consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. *[Applies when plan design includes 90 day generic coverage.]* • [As written by the provider, a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed $[10 - 20].] *[Applies when plan design includes contraceptive benefits.]* • [~~A one-cycle supply of a contraceptive.~~ You may obtain up to ~~three~~ 12 cycles of the same contraceptive 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. *[Applies when plan design includes [1]preferred retail network pharmacy and/or [2]non-preferred retail network pharmacy. [3]Applies when plan design includes both preferred and non-preferred retail network pharmacy.]* [We may designate certain retail Network Pharmacies to be [[1]a Preferred Retail Network Pharmacy] [[3]and/or] [[2]a Non-Preferred Retail Network Pharmacy]. We may periodically change the [[1]Preferred] [[3]and/or] [[2]Non-Preferred] designation of a retail Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a retail Network Pharmacy is a [[1]Preferred Retail Network Pharmacy] [[3]or a] [[2]Non-Preferred Retail Network Pharmacy] through the Internet at	*following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. 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: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per

Description and Supply Limits	Benefit (The Amount We Pay)
[www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when plan design includes preferred retail network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]* [If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.] *[Applies when plan design includes non-preferred retail network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]* [If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]	Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of

Description and Supply Limits	Benefit (The Amount We Pay)
	$[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-450] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.] *[Include when 90 day generic coverage applies.]* [For a 90-day supply of a Generic for which the Usual and

Description and Supply Limits	Benefit (The Amount We Pay)
	Customary Charge does not exceed $[10 - 20], we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after

Description and Supply Limits	Benefit (The Amount We Pay)
	you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of

Description and Supply Limits	Benefit (The Amount We Pay)
	Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Non-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. *[Applies when plan design includes contraceptive benefits.]* • [A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. 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: [50-100]% of the

Description and Supply Limits	Benefit (The Amount We Pay)
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.	Predominant Reimbursement Rate [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[25-450]]] [,] [and] [[50-100]% of the Predominant Reimbursement

Description and Supply Limits	Benefit (The Amount We Pay)
	Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[25-450]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[25-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[80-650]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[80-650]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[80-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[125-750]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[125-750]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[125-750]]] per Prescription Order or Refill].

Description and Supply Limits	Benefit (The Amount We Pay)
	[[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[175-850]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[175-850]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
[Applies when plan design includes a mail order benefit.] **[Prescription Drug Products from a Mail Order Network Pharmacy]**	
[The following supply limits apply: *[1 Applies when plan design includes specialty drug program.]* *[2 Apply when plan design includes the*	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of*

Description and Supply Limits	Benefit (The Amount We Pay)
list of preventive medications.] • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [[1]These supply limits do not apply to Specialty Prescription Drug Products[[2], including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.] *[Include if plan allows 1x copay at mail.]* [We may allow a 31 day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31 day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when coverage is initially required at a retail pharmacy prior to using mail order.]* [You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.] *[Applies when initial mail day supply is limited.]* [You may be limited to a 31-day supply for your initial fill and [1 - 3] refill[s] of certain Prescription Drug Products you obtain through a mail order Network Pharmacy.] *[Applies only when mail order Copayments and/or Coinsurance in the*	*preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[There are two copayment and/or coinsurance options. The first is to tie the number of days' supply to the copayment and/or coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a copayment and/or coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.]* *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 31-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a

Description and Supply Limits	Benefit (The Amount We Pay)
right hand column are charged for the full 90 day supply. Does not apply when Copayments and/or Coinsurance are tied to the 31, 60 and 90 day supply.] [To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.] *[Applies when plan design includes [1]preferred mail order network pharmacy and/or [2]non-preferred mail order network pharmacy. [3]Applies when plan design includes both preferred and non-preferred mail order network pharmacy.]* [We may designate a mail order Network Pharmacy to be [[1]a Preferred Mail Order Network Pharmacy] [[3]and/or] [[2]a Non-Preferred Mail Order Network Pharmacy]. We may periodically change the [[1]Preferred] [[3]and/or] [[2]Non-Preferred] designation of a mail order Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a mail order Network Pharmacy is a [[1]Preferred Mail Order Network Pharmacy] [[3]or a] [[2]non-Preferred Mail Order Network Pharmacy] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when plan design includes preferred mail order network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]* [If you use a Preferred Mail Order Network Pharmacy, your Copayment will be reduced by a minimum of $[1 -	Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]]

Description and Supply Limits	Benefit (The Amount We Pay)
60] per Prescription Order or Refill.] [If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.] *[Applies when plan design includes non-preferred mail order network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]* [If you use a Non-Preferred Mail Order Network Pharmacy, your Copayment will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]	[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-450] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more

Description and Supply Limits	Benefit (The Amount We Pay)
	than $[500-850]] per Prescription Order or Refill.]] *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 60-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-150]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-150]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-150]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-150]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-70]] [you will not pay more than $[70-150]] [you will not pay less than $[7-70] and you will not pay more than $[70-150]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-150]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-70]] [you will not pay more than $[70-150]] [you will not pay less than $[5-70] and you will not pay more than $[70-150]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-500]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-250]] [you will not pay more than $[250-500]] [you will not pay less than $[15-250] and you will not pay more than $[250-500]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-500]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-250]] [you will not pay more than $[250-500]] [you will not pay less than $[10-250] and you will not pay more than $[250-500]] per Prescription Order or Refill.]]

Description and Supply Limits	Benefit (The Amount We Pay)
	[For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-900]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-900]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-900]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-900]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-450]] [you will not pay more than $[450-900]] [you will not pay less than $[20-450] and you will not pay more than $[450-900]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-900]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-450]] [you will not pay more than $[450-900]] [you will not pay less than $[15-450] and you will not pay more than $[450-900]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-1,300]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-1,300]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-1,300]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-1,300]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-720]] [you will not pay more than $[720-1,300]] [you will not pay less than $[70-720] and you will not pay more than $[720-1,300]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,300]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-720]] [you will not pay more than $[720-1,300]] [you will not pay less than $[50-720] and you will not pay more than $[720-1,300]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-1,500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-1,500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for

Description and Supply Limits	Benefit (The Amount We Pay)
	Therapeutic Class [B] [after you pay a Copayment of $[100-1,500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-1,500]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-850]] [you will not pay more than $[850-1,500]] [you will not pay less than $[100-850] and you will not pay more than $[850-1,500]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,500]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-850]] [you will not pay more than $[850-1,500]] [you will not pay less than $[75-850] and you will not pay more than $[850-1,500]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-1,700]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-1,700]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-1,700]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-1,700]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-1,000]] [you will not pay more than $[1,000-1,700]] [you will not pay less than $[150-1,000] and you will not pay more than $[1,000-1,700]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,700]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-1,000]] [you will not pay more than $[1,000-1,700]] [you will not pay less than $[100-1,000] and you will not pay more than $[1,000-1,700]] per Prescription Order or Refill.]] *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 90-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-225]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-225]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-225]]] [, and] [[50-100]% of the Prescription Drug Charge for a

Description and Supply Limits	Benefit (The Amount We Pay)
	Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-225]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-105]] [you will not pay more than $[70-225]] [you will not pay less than $[7-105] and you will not pay more than $[70-225]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-225]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-105]] [you will not pay more than $[70-225]] [you will not pay less than $[5-105] and you will not pay more than $[70-225]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-375]] [you will not pay more than $[250-750]] [you will not pay less than $[15-375] and you will not pay more than $[250-750]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-375]] [you will not pay more than $[250-750]] [you will not pay less than $[10-375] and you will not pay more than $[250-750]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-1,350]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-1,350]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-1,350]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-1,350]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-675]] [you will not pay more than $[450-1,350]] [you will not pay less than $[20-675] and you will not pay more than $[450-1,350]] per Prescription Order or Refill.]]

Description and Supply Limits	Benefit (The Amount We Pay)
	[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,350]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-675]] [you will not pay more than $[450-1,350]] [you will not pay less than $[15-675] and you will not pay more than $[450-1,350]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-1,950]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-1,950]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-1,950]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-1,950]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-1,080]] [you will not pay more than $[720-1,950]] [you will not pay less than $[70-1,080] and you will not pay more than $[720-1,950]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,950]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-1,080]] [you will not pay more than $[720-1,950]] [you will not pay less than $[50-1,080] and you will not pay more than $[720-1,950]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-2,250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-2,250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-2,250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-2,250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-1,275]] [you will not pay more than $[850-2,250]] [you will not pay less than $[100-1,275] and you will not pay more than $[850-2,250]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-2,250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-1,275]] [you will not pay more than $[850-2,250]] [you will not pay less than $[75-1,275] and you will not pay

Description and Supply Limits	Benefit (The Amount We Pay)
	more than $[850-2,250]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-2,550]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-2,550]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-2,550]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-2,550]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-1,500]] [you will not pay more than $[1,000-2,550]] [you will not pay less than $[150-1,500] and you will not pay more than $[1,000-2,550]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-2,550]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-1,500]] [you will not pay more than $[1,000-2,550]] [you will not pay less than $[100-1,500] and you will not pay more than $[1,000-2,550]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum. For non-grandfathered plans that include a separate out-of-pocket drug maximum and/or separate specialty out-of-pocket drug maximum, any combination of the out-of-pocket drug maximum and the specialty drug product out-of-pocket maximum variables and the medical out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the medical out-of-pocket maximum can only be utilized for plans that include a separate medical and prescription drug out-of-pocket maximum or for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans.]

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

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

[Applies to plan designs that include closed-panel benefits. (Closed panel means that we pay only for drugs that are prescribed by a network provider.)]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

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

[Applies when plan design includes open benefit design.]

[[1]Ancillary charge references here and throughout the schedule apply when plan design includes the mandatory or restrictive program.]

[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 [[1]and an Ancillary Charge may apply]. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.]

[Applies when plan design includes closed benefit design.]

[[1]Applies when plan design includes the mandatory or restrictive program.]

[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 [[1]and an Ancillary Charge may apply,] or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.]

[Applies when plan design includes closed-panel benefits.]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

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.

[Variable references here and throughout are used to support either notification or prior authorization requirements.]

[Notification] [Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [notify] [obtain prior authorization from] us or our designee. The reason for [notifying] [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 [notify] [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 [Notification] [Prior Authorization]

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

If [we are not notified] [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 [notification] [prior authorization] are subject to our periodic review and modification. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may determine whether a particular Prescription Drug Product requires [notification] [prior authorization] through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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

[Therapeutic class charge and therapeutically equivalent charge (here and throughout) is variable by plan design.]

When you submit a claim on this basis, you may pay more because you did not [notify] [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] [, Therapeutic Class Charge] [, Therapeutically Equivalent 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 [notification] [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 [notification] [prior authorization], participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

[Step Therapy]

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

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

What You Must Pay

[The following bracketed provisions are variable based upon plan design.]

[You are responsible for paying the [Annual Drug Deductible] [and] [Specialty Prescription Drug Product Annual Deductible].]

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

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

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

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

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

[Benefits for [insulin] [or] [diabetic supplies] 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] [[, in addition to any] [or] Therapeutic Class Charge] [[, in addition to any] [or] Therapeutically Equivalent Charge]. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

[[1]Applies when the plan design includes the mandatory generic program.]

[An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your [[1]or the provider's] request and there is another drug that is ~~c~~Chemically Equivalent. ~~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 [lower tiered drug] [higher tier drug].~~ [An Ancillary Charge does not apply to any [Annual Drug Deductible] [,] [Annual Deductible] [,] [Specialty Prescription Drug Product Annual Deductible] [,] [or] [Out-of-Pocket Drug Maximum] [,] [or] [Out-of-Pocket Maximum] [or] [Specialty Prescription Drug Product Out-of-Pocket Maximum].]]

[A Therapeutic Class Charge may apply when the Prescription Drug Charge of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

[A Therapeutically Equivalent Charge may apply when the Prescription Drug Charge of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutically Equivalent Charge and any applicable Copayment and/or Coinsurance.]

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

- [Copayments for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Coinsurance for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Ancillary Charges.]
- [Therapeutic Class Charges.]
- [Therapeutically Equivalent Charges.]
- [The Annual Drug Deductible.]
- [The Specialty Prescription Drug Product Annual Deductible.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.]
- [Certain coupons or offers from pharmaceutical manufacturers. 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.]
- 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 following provisions are plan design variable.]

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

[The Specialty Prescription Drug Product Annual Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Out-of-Pocket Drug Maximums are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

[The Infertility Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Payment Term And Description	Amounts
[Annual Drug Deductible]	
[Annual drug deductible is plan design variable.] *[Option 1: Applies when the annual drug deductible is determined based on network status.]* [The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products.] *[Option 2: Applies when the annual drug deductible is determined based on tier status.]* [The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products.] [Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.] [Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.] [Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.] *[[1]Applies when only the individual portion is subject to the annual drug deductible.]*	*[The variables below correspond with Option 1.]* [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] *[The variables below correspond with Option 2.]* ***[Tier 1]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 2]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 3]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 4]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]

Payment Term And Description	Amounts
[Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [[1]This carry-over feature applies only to the individual Annual Drug Deductible.]] [When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.] *[Applies when the roll-over provision applies to a group changing from a calendar year to policy year plan.]* *[[1]Applies when only the individual portion is subject to the annual drug deductible.]* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual 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 5]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 6]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5] [and] [6]]*** [No Annual Drug Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[Specialty Prescription Drug Product Annual Deductible]	
[Specialty annual deductible is plan design variable.] *[Option 1: Applies when the specialty*	*[The variable provisions below correspond with Option 1.]* ***[Specialty Prescription Drug Product]*** *[Include when individual specialty prescription drug product deductible*

Payment Term And Description	Amounts
annual deductible is determined based on either specialty prescription drug product, per specialty drug product, per therapeutic class and/or growth hormone therapy.]	*applies.]*
[The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.]	[$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products.] [This does not include any deductible stated below.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [This does not include any deductible stated below.] ***[Specialty - Per Specialty Prescription Drug Product]*** [$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any deductible stated below.] [$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person, not to exceed $[200 - 3,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any deductible stated below.]
[Option 2: Applies when the specialty annual deductible is determined based on tier status.]	***[Specialty - Growth Hormone Therapy]*** [$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] [$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[200 - 3,000] for growth hormone therapy for all Covered Persons in a family.]
[The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.]	***[Specialty - Per Therapeutic Class]*** [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class A.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class B.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B, not to exceed $[200 - 3,000] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class C.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C.] [$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[[1]Applies when only the individual portion of the specialty prescription drug product annual deductible is subject to the carry-over feature.]	*[The variable provisions below correspond with Option 2.]*
[Any amount you pay that is applied to the Specialty Prescription Drug Product Annual Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current year's Specialty Prescription Drug Product Annual Deductible. [[1]This carry-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]]	
[When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that specialty prescription drug product annual deductible provision of the prior policy will apply to the Specialty Prescription Drug Product Annual Deductible provision under the Policy.]	
[[1]Applies when only the individual portion of the specialty prescription drug	

Payment Term And Description	Amounts
product annual deductible is subject to the roll-over provision for groups changing from a calendar year to policy year plan.] [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Specialty Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Specialty Prescription Drug Product Annual Deductible, will be rolled over and applied to the current Policy year Specialty Prescription Drug Product Annual Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]] [The Specialty Prescription Drug Product Annual Deductible is included in the overall Annual Drug Deductible stated above.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Annual 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 Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 2]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 3]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 4]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 5]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tier 6]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.] ***[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5] [and] [6]]*** [No Specialty Prescription Drug Product Annual Deductible.] [$[100 - 1,000] per Covered Person.] [$[100 - 1,000] per Covered Person, not to exceed $[200 - 3,000] for all Covered Persons in a family.]
[Out-of-Pocket Drug Maximum]	
[Out-of-pocket drug maximum is plan	*[Insert maximum amounts according to benefit design chosen by group.]*

Payment Term And Description	Amounts
design variable. Include applicable provisions to support the following:] *[1The out-of-pocket drug maximum applies annually.]* *[2The annual out-of-pocket drug maximum includes copayments.]* *[3The annual out-of-pocket drug maximum does not include copayments.]* *[4The out-of-pocket drug maximum applies monthly.]* *[5The monthly out-of-pocket drug maximum includes copayments.]* *[6The monthly out-of-pocket drug maximum does not include copayments.]*	*[1Include if copayments and coinsurance are not subject to an out-of-pocket drug maximum.]* *[2Include if copayments and/or coinsurance are subject to an out-of-pocket drug maximum and the benefit design includes an annual drug deductible.]* *[3If an annual drug deductible applies, select the appropriate statement about whether or not the annual drug deductible applies to the out-of-pocket drug maximum.]*
[1The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [2Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [3The Out-of-Pocket Drug Maximum does not include Copayments.]]	*[Include when individual out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person.] *[Include when individual (with family maximum) out-of-pocket drug maximum applies.]* [$[500 - 10,000] per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.]
[4The maximum amount you are required to pay for covered Prescription Drug Products in a single calendar month. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [5Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the calendar month. [6The Out-of-Pocket Drug Maximum does not include Copayments.]]	[1Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [2The Out-of-Pocket Drug Maximum [3includes] [3does not include] the Annual Drug Deductible.]
[Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by the Out-of-Pocket Drug Maximum.]	
[Copayments and Coinsurance for covered Prescription Drug Products for Infertility are not limited by the Out-of-Pocket Drug Maximum.]	
[Coupons: We may not permit certain coupons or offers from pharmaceutical	

Payment Term And Description	Amounts
manufacturers to apply to your Out-of-Pocket Drug Maximum. 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.]	
[Specialty Prescription Drug Product Out-of-Pocket Maximum]	
[Specialty out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:] *[1The specialty out-of-pocket drug maximum applies annually.]* *[2The specialty annual out-of-pocket drug maximum includes copayments.]* *[3The specialty annual out-of-pocket drug maximum does not include copayments.]* *[4The specialty out-of-pocket drug maximum applies monthly.]* *[5The specialty monthly out-of-pocket drug maximum includes copayments.]* *[6The specialty monthly out-of-pocket drug maximum does not include copayments.]* [1The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [2Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the year. [3The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]] [4The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single calendar month. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [5Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the	***[Specialty Prescription Drug Product]*** *[Include when individual specialty out-of-pocket maximum applies.]* [$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person.] [This does not include any maximum stated below.] *[Include when individual (with family maximum) specialty out-of-pocket maximum applies.]* [$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [This does not include any maximum stated below.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] ***[Specialty - Per Specialty Prescription Drug Product]*** [$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any maximum stated below.] [$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person, not to exceed $[1,000 - 30,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any maximum stated below.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] ***[Specialty - Growth Hormone Therapy]*** [$[500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[1,000 - 30,000] for growth hormone therapy for all Covered Persons in a family.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]

Payment Term And Description	Amounts
remainder of the calendar month. [[6]The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]] [Copayments and Coinsurance for covered Specialty Prescription Drug Products for Infertility are not limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.] [Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Out-of-Pocket Maximum. 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.]	***[Specialty - per Therapeutic Class]*** [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person.] [$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person, not to exceed $[1,000 - 30,000] for all Covered Persons in a family.] [Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]
[Infertility Annual Maximum Benefit]	
[Applicability of infertility annual maximum drug benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.]	[$[250 - 10,000] per Covered Person.]
[Infertility Maximum Policy Benefit]	
[Applicability of infertility maximum	[$[250 - 10,000] per Covered Person.]

Payment Term And Description	Amounts
policy benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.]	
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. *[Include when regimen pricing applies to therapeutic treatments.]* [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 [notification] [prior authorization], participation or activation requirements	*[[1]Applies when our negotiated rate does not apply.]* *[[2]Applies when our negotiated rate applies.]* For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the [[1]lower] [[2]lowest] of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • [[2]The Prescription Drug Charge for that Prescription Drug Product.] [For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product.] See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

Payment Term And Description	Amounts
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. *[Include when Copayment/Coinsurance Waiver Program applies.]* [**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	

Payment Term And Description	Amounts
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)
[The specialty prescription drug product benefit description is plan design variable.] **[Specialty Prescription Drug Products]**	
[The following supply limits apply. • As written by the provider, up to a consecutive ~~[~~31~~] [60]~~-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive ~~[~~31~~]~~-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[Applies when smart fill program applies]* [If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.] Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [,] [or] [a mail order Network Pharmacy] [or] [a Designated Pharmacy].]	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments/coinsurance for growth hormone therapy; differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] [For a Tier 1 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[0-75]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[15-250]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug

Description and Supply Limits	Benefit (The Amount We Pay)
	Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[20-450]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[25-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[25-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[25-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[70-650]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[80-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[80-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[80-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription

Description and Supply Limits	Benefit (The Amount We Pay)
	Order or Refill.]] [For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[100-750]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[125-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[125-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[125-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of $[150-850]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[175-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[175-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not

Description and Supply Limits	Benefit (The Amount We Pay)
	pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Specialty Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
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. *[Applies when plan design includes 90 day generic coverage.]* • [As written by the provider, a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed $[10 - 20].] *[Applies when plan design includes contraceptive benefits.]* • [~~A one-cycle supply of a contraceptive.~~ You may obtain up to ~~three~~ 12 cycles of the same contraceptive 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. *[Applies when plan design includes [1]preferred retail network pharmacy and/or [2]non-preferred retail network pharmacy. [3]Applies when plan design includes both preferred and non-preferred retail network pharmacy.]* [We may designate certain retail Network Pharmacies to be [[1]a Preferred Retail Network Pharmacy] [[3]and/or] [[2]a	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. 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: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than

Description and Supply Limits	Benefit (The Amount We Pay)
Non-Preferred Retail Network Pharmacy]. We may periodically change the [[1]Preferred] [[3]and/or] [[2]Non-Preferred] designation of a retail Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a retail Network Pharmacy is a [[1]Preferred Retail Network Pharmacy] [[3]or a] [[2]Non-Preferred Retail Network Pharmacy] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when plan design includes preferred retail network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]* [If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.] *[Applies when plan design includes non-preferred retail network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]* [If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Retail	$[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after

Description and Supply Limits	Benefit (The Amount We Pay)
Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]	you pay a Copayment of $[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-450] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.] *[Include when 90 day generic coverage applies.]* [For a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed $[10 - 20], we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B]

Description and Supply Limits	Benefit (The Amount We Pay)
	[after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription

Description and Supply Limits	Benefit (The Amount We Pay)
	Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20 per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than $[0-15]] [you will not pay more than $[0-20]] [you

Description and Supply Limits	Benefit (The Amount We Pay)
	will not pay less than $[0-15] and you will not pay more than $[0-20]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]
[Applies when plan design includes a mail order benefit.] **[Prescription Drug Products from a Mail Order Network Pharmacy]**	
[The following supply limits apply: *[[1]Applies when plan design includes specialty drug program.]* *[[2]Apply when plan design includes the list of preventive medications.]* • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [[1]These supply limits do not apply to Specialty Prescription Drug Products[[2], including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.] *[Include if plan allows 1x copay at mail.]* [We may allow a 31 day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31 day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number	*[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]* [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 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[There are two copayment and/or coinsurance options. The first is to tie the number of days' supply to the copayment and/or coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a copayment and/or coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.]* *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 31-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-35]] [you will not pay more than $[35-75]] [you will not pay less than $[7-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-35]] [you will not pay more than $[35-75]] [you

Description and Supply Limits	Benefit (The Amount We Pay)
on your ID card.] *[Applies when coverage is initially required at a retail pharmacy prior to using mail order.]* [You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.] *[Applies when initial mail day supply is limited.]* [You may be limited to a 31-day supply for your initial fill and [1 - 3] refill[s] of certain Prescription Drug Products you obtain through a mail order Network Pharmacy.] *[Applies only when mail order Copayments and/or Coinsurance in the right hand column are charged for the full 90 day supply. Does not apply when Copayments and/or Coinsurance are tied to the 31, 60 and 90 day supply.]* [To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.] *[Applies when plan design includes [1]preferred mail order network pharmacy and/or [2]non-preferred mail order network pharmacy. [3]Applies when plan design includes both preferred and non-preferred mail order network pharmacy.]* [We may designate a mail order Network Pharmacy to be [[1]a Preferred Mail Order Network Pharmacy] [[3]and/or] [[2]a Non-Preferred Mail Order Network Pharmacy]. We may periodically change the [[1]Preferred] [[3]and/or] [[2]Non-Preferred] designation of a mail order Network Pharmacy. These changes	will not pay less than $[5-35] and you will not pay more than $[35-75]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-125]] [you will not pay more than $[125-250]] [you will not pay less than $[15-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-125]] [you will not pay more than $[125-250]] [you will not pay less than $[10-125] and you will not pay more than $[125-250]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-450]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-450]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-225]] [you will not pay more than $[225-450]] [you will not pay less than $[20-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-225]] [you will not pay more than $[225-450]] [you will not pay less than $[15-225] and you will not pay more than $[225-450]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-

Description and Supply Limits	Benefit (The Amount We Pay)
generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a mail order Network Pharmacy is a [[1]Preferred Mail Order Network Pharmacy] [[3]or a] [[2]non-Preferred Mail Order Network Pharmacy] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Applies when plan design includes preferred mail order network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]* [If you use a Preferred Mail Order Network Pharmacy, your Copayment will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of $[1 - 60] per Prescription Order or Refill.] [If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.] *[Applies when plan design includes non-preferred mail order network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]* [If you use a Non-Preferred Mail Order Network Pharmacy, your Copayment will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of $[1 - 60] per Prescription Order or Refill.] [If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]	360]] [you will not pay more than $[360-650]] [you will not pay less than $[70-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-360]] [you will not pay more than $[360-650]] [you will not pay less than $[50-360] and you will not pay more than $[360-650]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-425]] [you will not pay more than $[425-750]] [you will not pay less than $[100-450] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-425]] [you will not pay more than $[425-750]] [you will not pay less than $[75-425] and you will not pay more than $[425-750]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-500]] [you will not pay more than $[500-850]] [you will not pay less than $[150-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-500]] [you will not pay more than $[500-850]] [you will not pay less than $[100-500] and you will not pay more than $[500-850]] per Prescription Order or Refill.]] *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]*

Description and Supply Limits	Benefit (The Amount We Pay)
	[For up to a 60-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-150]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-150]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-150]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-150]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-70]] [you will not pay more than $[70-150]] [you will not pay less than $[7-70] and you will not pay more than $[70-150]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-150]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-70]] [you will not pay more than $[70-150]] [you will not pay less than $[5-70] and you will not pay more than $[70-150]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-500]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-250]] [you will not pay more than $[250-500]] [you will not pay less than $[15-250] and you will not pay more than $[250-500]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-500]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-250]] [you will not pay more than $[250-500]] [you will not pay less than $[10-250] and you will not pay more than $[250-500]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-900]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-900]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-900]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-900]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-450]] [you will not pay more than $[450-900]] [you will not pay less than $[20-450] and you will not pay more than $[450-900]] per Prescription

Description and Supply Limits	Benefit (The Amount We Pay)
	Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-900]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-450]] [you will not pay more than $[450-900]] [you will not pay less than $[15-450] and you will not pay more than $[450-900]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-1,300]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-1,300]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-1,300]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-1,300]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-720]] [you will not pay more than $[720-1,300]] [you will not pay less than $[70-720] and you will not pay more than $[720-1,300]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,300]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-720]] [you will not pay more than $[720-1,300]] [you will not pay less than $[50-720] and you will not pay more than $[720-1,300]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-1,500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-1,500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-1,500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-1,500]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-850]] [you will not pay more than $[850-1,500]] [you will not pay less than $[100-850] and you will not pay more than $[850-1,500]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,500]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-850]] [you will not pay more than $[850-1,500]] [you will not pay less than $[75-850] and you will not pay more than $[850-1,500]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-1,700]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-1,700]]] [,] [and] [[50-

Description and Supply Limits	Benefit (The Amount We Pay)
	100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-1,700]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-1,700]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-1,000]] [you will not pay more than $[1,000-1,700]] [you will not pay less than $[150-1,000] and you will not pay more than $[1,000-1,700]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,700]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-1,000]] [you will not pay more than $[1,000-1,700]] [you will not pay less than $[100-1,000] and you will not pay more than $[1,000-1,700]] per Prescription Order or Refill.]] *[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]* [For up to a 90-day supply, we pay:] [For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-225]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[0-225]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[0-225]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[0-225]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[7-105]] [you will not pay more than $[70-225]] [you will not pay less than $[7-105] and you will not pay more than $[70-225]] per Prescription Order or Refill.]] [For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-225]] per Prescription Order or Refill. [[However,] [you will not pay less than $[5-105]] [you will not pay more than $[70-225]] [you will not pay less than $[5-105] and you will not pay more than $[70-225]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[15-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[15-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[15-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[15-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[15-375]] [you will not pay more than $[250-750]] [you will not pay less than $[15-375] and you will not pay more than $[250-750]] per Prescription Order or Refill.]] [For a Tier 2 Prescription Drug Product on the List of Preventive

Description and Supply Limits	Benefit (The Amount We Pay)
	Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than $[10-375]] [you will not pay more than $[250-750]] [you will not pay less than $[10-375] and you will not pay more than $[250-750]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[20-1,350]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[20-1,350]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[20-1,350]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[20-1,350]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[20-675]] [you will not pay more than $[450-1,350]] [you will not pay less than $[20-675] and you will not pay more than $[450-1,350]] per Prescription Order or Refill.]] [For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,350]] per Prescription Order or Refill. [[However,] [you will not pay less than $[15-675]] [you will not pay more than $[450-1,350]] [you will not pay less than $[15-675] and you will not pay more than $[450-1,350]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[70-1,950]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[70-1,950]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[70-1,950]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[70-1,950]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[70-1,080]] [you will not pay more than $[720-1,950]] [you will not pay less than $[70-1,080] and you will not pay more than $[720-1,950]] per Prescription Order or Refill.]] [For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-1,950]] per Prescription Order or Refill. [[However,] [you will not pay less than $[50-1,080]] [you will not pay more than $[720-1,950]] [you will not pay less than $[50-1,080] and you will not pay more than $[720-1,950]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[100-2,250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[100-2,250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[100-2,250]]] [,

Description and Supply Limits	Benefit (The Amount We Pay)
	and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[100-2,250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[100-1,275]] [you will not pay more than $[850-2,250]] [you will not pay less than $[100-1,275] and you will not pay more than $[850-2,250]] per Prescription Order or Refill.]] [For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-2,250]] per Prescription Order or Refill. [[However,] [you will not pay less than $[75-1,275]] [you will not pay more than $[850-2,250]] [you will not pay less than $[75-1,275] and you will not pay more than $[850-2,250]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[150-2,550]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of $[150-2,550]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of $[150-2,550]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of $[150-2,550]]] per Prescription Order or Refill]. [[However,] [you will not pay less than $[150-1,500]] [you will not pay more than $[1,000-2,550]] [you will not pay less than $[150-1,500] and you will not pay more than $[1,000-2,550]] per Prescription Order or Refill.]] [For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of $[0-2,550]] per Prescription Order or Refill. [[However,] [you will not pay less than $[100-1,500]] [you will not pay more than $[1,000-2,550]] [you will not pay less than $[100-1,500] and you will not pay more than $[1,000-2,550]] per Prescription Order or Refill.]] [No Copayment] *[Applies when closed benefit plan applies.]* [Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.

[1Use the "including" statement when any of the ~~three~~ four Riders are part of the medical plan.]

[2Include the GID Rider when issued as part of the medical plan.]

[3 Include the Outpatient Prescription Drug Rider except when issued to a group that has carved out RX benefits from their medical plan.]

[~~4~~3Include pediatric dental and vision references when issued as part of the medical plan. Do not include if those products are being sold as stand-alone products.]

- Riders[1, including [2the Gender Identify Disorder/Gender Dysphoria Treatment Rider] [,] [and] [3the *Outpatient Prescription Drug Rider*][,][and] [~~3the~~ 4the *Pediatric Dental Rider*] [and] [~~3the~~ 4the *Pediatric Vision Care Services Rider*]].
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

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

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

Other Information You Should Have

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

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

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the District of Columbia. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of District of Columbia are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

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

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

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

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

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

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

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

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

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

Be Aware this Benefit Plan Does Not Pay for All Health Services

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

[Product Variables:]

[[1]Network/Non-Network plans, including Options PPO when network providers are responsible for prior authorization.]

[[2]Network-only plans.]

[[3]Options PPO when network providers are not responsible for prior authorization or Non-Differential PPO when prior authorization is required for any service.]

Some Covered Health Services require prior authorization. [[1]In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services.] [[2]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.] [[3]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. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the ~~discretion~~ final authority to do the following:

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

We may delegate this ~~discretionary~~ authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time ~~in our discretion~~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 Benefit plan.

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, ~~in our discretion~~as we determine, 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 going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

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

Notify You of Material Modifications

From time to time, your plan may change (i.e. Deductible/coinsurance, etc.) but before the change can go into effect, we will provide you with a 60 day notice of any material modification, including changes to preventive care benefits.

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

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

[Plan design variable.]

- The amount you must pay for these Covered Health Services (including any Annual Deductible, [Per Occurrence Deductible,] Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount 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."

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design. Include any other specific conditions for coverage described within the category.]

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

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

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.

- Acupuncturist.]

[2.] Ambulance Services

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

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

- From a non-Network Hospital to the closest~~a~~ Network Hospital.
- To the closest Network~~a~~ Hospital or facility that provides ~~a higher level of care~~Covered Health Services that were~~as~~ not available at the original Hospital or facility.
- ~~To a more cost-effective acute care facility.~~
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.

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

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

  ~~• From an acute facility to a sub-acute setting.~~

[3.] 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.

[Include to support expanding clinical trial benefit to non-life-threatening cardiovascular disease.]

- [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.]

[Include to support expanding clinical trial benefit to non-life-threatening surgical musculoskeletal disorders.]

- [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.]
- ~~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.~~

[Include to support expanding clinical trial benefit to other non-life-threatening diseases or disorders.]

- [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 service or item, 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. A category B device is a non-experimental/investigational device:
    - For which the underlying questions of safety and effectiveness for that device have been resolved, or;
    - Is known to be safe and effective because, for example, other manufacturers have obtained *FDA* approval or clearance for that device.
  - 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.

[Include to support expanding clinical trial benefit beyond PPACA requirements.]

[[1]Include when clinical trial benefit is expanded for cardiovascular disease. [2]Include when clinical trial benefit is expanded for musculoskeletal disorders. [3]Include when clinical trial benefit is expanded for other non-life-threatening diseases or disorders.]

[With respect to [[1]cardiovascular disease] [,] [and] [[2]musculoskeletal disorders of the spine, hip and knees] [,] [and] [[3]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.]

~~*[[1]Include to support expanding clinical trial benefit to other non-life-threatening diseases or disorders.]*~~

~~*[[2]Include when clinical trial benefit is not expanded to other non-life-threatening diseases or disorders.]*~~

~~With respect to cardiovascular disease or musculoskeletal disorders of the spine[1,] [2and] hip and knees [1and 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)*, the *NCI Community Clinical Oncology Program*, the *NCI Clinical Trials Cooperative Group*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - The *AIDS Clinical Trials Group*.
  - The *Community Programs for Clinical Research in AIDS*.
  - 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*) and registered with the *Department of Health and Human Services* that is associated with an institution that has a federal-wide assurance approved by the *Department of Health and Human Services* 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 the Policy.

[4.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

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

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

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

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

- Emergency 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.]

[6.] 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.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management for that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes. We have specific guidelines regarding benefits for Diabetes services. Contact us at the telephone number on the back of your ID card for information about these guidelines.

Diabetic Self-Management Items

[Durable Medical Equipment and Outpatient Prescription Drug coverage are variable only for groups that are not required to provide coverage for Essential Health Benefits.]

[Include paragraph below when group purchases the drug rider.]

[[1]Include only when group purchases benefits for durable medical equipment.]

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. [[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors[, including continuous glucose monitors], insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

[Include paragraph and bulleted list below when group does not purchase the drug rider.]

[[1]Include only when group does not purchase benefits for durable medical equipment.]

[[2]Include only when group purchases benefits for durable medical equipment.]

[Insulin pumps [[1]that are not fully implanted into the body] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- [[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors[, including continuous glucose monitors].
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

[Durable Medical Equipment is variable only for groups that are not required to provide coverage for Essential Health Benefits.]

[7.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

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

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- ~~Delivery pumps for tube feedings (including tubing and connectors).~~
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

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

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

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

Benefits are available for repairs and replacement, except that:

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

[8.] 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).

In addition, reimbursement for the cost of one voluntary HIV screening test performed on the insured while receiving emergency medical services is permitted per year, regardless of necessity, per state mandate. HIV screening test shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by conducting a rapid-result test by means of the swabbing of a patient's gums, finger-prick blood test, or other suitable rapid-result test.

[Include if plan design includes retrospective review of emergency services.]

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

[9.] [Hearing Aids]

[Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs.

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] 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.

[11.] 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.

[12.] 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*.)

Coverage is provided for newborn infant hearing screenings and all necessary audio-logical examinations provided as recommended by the *National Joint Committee* on Infant Hearing. For the purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- [Be under age 44, if female.]
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.]

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 for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable, but not limited to, mammography testing performed as follows:
  - A baseline mammogram; and
  - Follow-up mammograms on an annual basis.
- Colorectal cancer screening: Coverage shall be provided for colorectal cancer screening in accordance with the latest screening guidelines issued by the *American Cancer Society* for the ages, family histories, and frequencies referenced in such guidelines.
- Prostate cancer screening: Coverage shall be provided for Prostate cancer screening in accordance with the latest screening guidelines issued by the *American Cancer Society* for the ages, family histories, and frequencies referenced in such guidelines.

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*.)

[Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.]

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

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

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

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

[Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.]

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*.)

[Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.]

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

[16.] Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following ~~services~~levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.

- Crisis intervention.
- ~~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.~~
- ~~Services at a Residential Treatment Facility.~~
- ~~Intensive Outpatient Treatment.~~

The Mental Health/Substance Use Disorder Designee ~~determines coverage~~provides administrative services for all levels of care. ~~If an Inpatient Stay is required, it is covered on a Semi-private Room basis.~~

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

~~**Special Mental Health Programs and Services**~~

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

[17.] Neurobiological Disorders - Autism Spectrum Disorder Services

Behavioral services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavioral Analysis (ABA))* that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision.

~~Psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:~~

- ~~Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.~~
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

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

Benefits include the following ~~services provided on either an inpatient or outpatient basis~~levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- ~~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.~~
- ~~Services at a Residential Treatment Facility.~~
- ~~Intensive Outpatient Treatment.~~

The Mental Health/Substance Use Disorder Designee ~~determines coverage~~provides administrative services for all levels of care. ~~If an Inpatient Stay is required, it is covered on a Semi-private Room basis.~~

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

[18.] [Obesity Surgery]

[Include the applicable criteria for coverage].

[Surgical treatment of obesity when provided by or under the direction of a Physician [when the Covered Person has a body mass index (BMI) greater than 40].

[Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- [The Covered Person must have a body mass index (BMI) of greater than 40.]
- [The Covered Person must have a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

[19.] [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.]

[20.] 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. [Benefits under this section do not include medications for the treatment of infertility.]

[Pharmaceutical Products are assigned to various tiers. The ~~Pharmaceutical Product~~Prescription Drug List (PDL) Management Committee makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether prior authorization requirements should apply. Economic factors may include the Pharmaceutical Product's acquisition cost, including available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

Note: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

[If you require certain Pharmaceutical Products[, including specialty Pharmaceutical Products,] we may 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.

[[1] Applies to Network/Non-Network products.]

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, [[1]Network] 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.]

[Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Copayment and/or Coinsurance, you may receive Pharmaceutical Products 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 order or refill and/or the amount dispensed per month's supply.

You may determine whether a Pharmaceutical 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.]

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.

[21.] 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.

[22.] 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.

[[1]Include when Genetic Testing must be preceded by genetic counseling.]

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is [[1]determined to be Medically Necessary following genetic counseling when] 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*.

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. [2]Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.]

[Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [[2]Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.]]

[Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.]

[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*.]

[23.] 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.

In all cases of early discharge, we shall provide coverage for post-delivery care within the minimum time periods shown above in the Subscriber's home, or, in a provider's office, as determined by the Physician in consultation with the mother.

The at-home post-delivery care shall be provided by a registered professional nurse, Physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

(1). Parental education;

(2) Assistance and training in breast or bottle feeding; and

(3) Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

[24.] Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- 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* including those considered routine and necessary for newborn children from birth to 36 months of age.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* including annual cytology screening and any such screening deemed Medically Necessary by the Physician.

[[1]Include if information is available online.]

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 [[1]by going to [www.myuhc.com] or] 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.

Benefits for the services listed below are required under District of Columbia law:

- Preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy. Child health screenings and immunizations are covered for children from birth to age 21.
- With respect to women: annual cervical cytologic screening (pap smear) for women; and cervical cytologic screening for women upon certification by an attending physician that the test is medically necessary; a baseline mammogram for women; and an annual screening mammogram for women.
- Coverage must be provided for prostate cancer screening in accordance with the latest prostate cancer screening guidelines issued by the *American Cancer Society* for the ages, family histories and frequencies referenced in such guidelines.
- Coverage must be provided for colorectal cancer screening in compliance with the *American Cancer Society* colorectal cancer screening guidelines.

[Prosthetic Devices is variable only for groups that are not required to provide coverage for Essential Health Benefits.]

[25.] [Prosthetic Devices]

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

- Artificial arms, legs, feet and hands. Artificial face, eyes, ears and nose, including any portion of an artificial arm, leg, foot or hand.
- 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.]

[26.] Reconstructive Procedures

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

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

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998* and women's rights regarding certain health insurance as mandated by District of Columbia, including breast prostheses and treatment of complications at all stages of mastectomy including lymphedemas, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[Rehabilitation Services is variable only for groups that are not required to provide coverage for Essential Health Benefits.]

[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]

[[1]Include when adding Essential Health Benefits.]

[Short-term outpatient rehabilitation services [[1](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.
- [Vision therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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~~ ~~t~~Treatment.~~]~~

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

[[1]Include when adding Essential Health Benefits.]

[[1]Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- 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. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition 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 ~~r~~Residential ~~t~~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.

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. 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, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.~~

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.]

~~*[1]Include when adding Essential Health Benefits.*~~

~~[2]*Include when Essential Health Benefits are not added.*~~

~~[[1]Other than as described under *Habilitative Services* above, please] [[2]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.]~~

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.]

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 diagnostic 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*.)

[Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.]

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

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

[29.] 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.

[30.] Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following ~~services~~levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments..
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

[Include when plan design includes coverage for transitional living services.]

- [Transitional Living services.]
- ~~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.~~
- ~~Services at a Residential Treatment Facility.~~

- ~~Intensive Outpatient Treatment.~~

The Mental Health/Substance Use Disorder Designee ~~determines coverage~~provides administrative services for all levels of care. ~~If an Inpatient Stay is required, it is covered on a Semi-private Room basis.~~

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

~~**Special Substance Use Disorder Programs and Services**~~

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

[31.] Surgery - Outpatient

[[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.]

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]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.

[[1]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*.)

[Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.]

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

[32.] [Temporomandibular Joint Services]

[Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

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

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.

- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.]

[33.] Therapeutic Treatments - Outpatient

[Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.]

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*.

[Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.]

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

[34.] 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.

Coverage includes the treatment of breast cancer, lymphoma, and leukemia by dose-intensive chemotherapy or stem cell transplants when performed in accordance with protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, *National Cancer Institute* protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in such procedures.

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

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

[35.] 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*.

[36.] [Virtual Visits]

[Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

[[1]Product and state mandate variable. Include when Non-Network Benefits are available. Standard is to provide these services as network only, however in states that require both network and non-network benefits be available (in products that have a non-network level of benefits) include this "Network" reference.]

[[1]Network] Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

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

Benefits under this section do not include email[,] [or] fax [and standard telephone calls], or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).]

[37.] [Vision Examinations]

[[1]Include when plan design is set up to avoid double coverage for pediatric vision benefits which may be covered under either the Pediatric Vision Care Services Rider or if group is covering them under a stand-alone vision plan.]

[[2]Include when pediatric vision benefits are covered under the Pediatric Vision Care Services Rider.]

[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office [[1]for Covered Persons over the age of [19 - 21].] [[2]Benefits for Covered Persons age [19 - 21] and younger are provided as described in the Pediatric Vision Care Services Rider.]

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

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

[38.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By District of Columbia Law

[39.] Child Health Screenings and Immunizations

Screening tests and immunizations as required by the *Uniform Child Health Screenings and Reporting Form Act of 2004*. Coverage includes but is not limited to, the tests and immunizations listed in the *District of Columbia Child Health Certificate*.

[40.] Habilitative Services

Except for Habilitative Services provided in early intervention and school services, Habilitative Services for children 0 - 21 years old. "Habilitative Services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic

birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or Autism Spectrum Disorder, and (b) cerebral palsy.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

[Include bracketed variable exclusions below to support plan design. Unbracketed exclusions will always appear.]

A. Alternative Treatments

1. Acupressure [and acupuncture].
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [Manipulative Treatment and] non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

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

   [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.]

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

~~[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.]~~

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

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech [except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

6. Oral appliances for snoring.

[The following #7 & 8 apply when benefits are provided for prosthetics.]

[7.] [Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

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

[Applies when benefits are not provided for prosthetics.]

[7.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

D. Drugs

Except as law mandates:

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. This exclusion also does not apply to chemotherapy pills and hormone replacement therapy, for which Benefits are required under District of Columbia insurance law.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

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

[10.] A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

[11.] Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

E. Experimental or Investigational or Unproven Services

Except as law mandates:

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. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

[[1]Applies when plan design does not include benefits for durable medical equipment.]

[[2]Applies when plan design includes benefits for durable medical equipment.]

G. Medical Supplies [[1]and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.
   - [Ostomy supplies.]

   This exclusion does not apply to:
   - [[2]Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

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

[3.] [[1]Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders

Except as law mandates:

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, Neurobiological/Autism Spectrum, and Substance Use Disorder Services* in *Section 1: Covered Health Services.*

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

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.

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

5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

[Applies when plan design does not include coverage for transitional living services.]

[7.] [Transitional Living services.]~~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, sexual dysfunction, communication disorders, motor 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 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. 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 as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.~~

~~9. Autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum~~

disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

10. 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*.

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

12. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

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

I. Neurobiological Disorders - Autism Spectrum Disorder

Except as law mandates:

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. 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.

2. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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

4. 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.

5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

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

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

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

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

~~J~~I. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:~~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.
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 and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.

- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

~~L~~K. Physical Appearance

Except as law mandates:

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

[6.] [Wigs regardless of the reason for the hair loss.]

~~M~~L. Procedures and Treatments

Except as law mandates:

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.

[Applies when plan design includes benefits for rehabilitation services.]

[4.] [Rehabilitation services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.]

[Applies when plan design includes benefits for rehabilitation services.]

[5.] [Rehabilitation services for ~~S~~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.]

[Applies when plan design includes benefits for rehabilitation services.]

[6.] [Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[Applies when plan design does not include benefits for rehabilitation services.]

[4.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy.]

[7.] Psychosurgery.

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

[9.] Biofeedback.

[Applies when plan design does not include benefits for manipulative treatment.]

[10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[Applies when plan design does not include benefits for TMJ.]

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

[Applies when plan design includes benefits for TMJ.]

[11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.]

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

[13.] [Surgical and non-surgical treatment of obesity.] [Non-surgical treatment of obesity.] [Surgical treatment of obesity for open vertical banded gastroplasty and laparoscopic vertical banded gastroplasty.]

[Applies when plan design requires that obesity surgery be received at a Designated Facility. Will only apply when obesity surgery is not available at the non-network benefit level.]

[14.] [Obesity surgery that is not received at a Designated Facility.]

[15.] 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.

[Applies when plan design does not include benefits for breast reduction.]

[16.] [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*.]

[Applies when plan design includes benefits for breast reduction.]

[16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

[Applies when plan design requires that infertility services be received at a Designated Facility. Will only apply when infertility services are not available at the non-network benefit level.]

[17.] [Infertility services that are not received at a Designated Facility.]

[Applies when plan design includes benefits for infertility services.]

[18.] [In vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility.]

[Applies when plan design does not include benefits for infertility services.]

[18.] [In vitro fertilization regardless of the reason for treatment.]

[Applies when plan design requires that implantation of ventricular assist devices be performed at a Designated Facility.]

[19.] [Ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that Network Benefits for implantation of ventricular assist devices be performed at a Designated Facility.]

[20.] [Network Benefits for ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that CHD surgeries be performed at a Designated Facility. Will only apply when CHD surgery is not available at the non-network benefit level.]

[21.] [Congenital Heart Disease surgery that is not performed at a Designated Facility.]

~~N~~M. Providers

1. Services performed by a provider who is a family member by birth or marriage, [Domestic Partnership] or legal partnership. Examples include a spouse, [Domestic Partner,] legal partner, 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 ~~f~~Free~~-~~standing Facility or diagnostic Hospital-based ~~diagnostic f~~Facility without an order written by a Physician or other provider. Services which are self-directed to a ~~f~~Free~~-~~standing Facility or diagnostic Hospital-based ~~diagnostic f~~Facility. Services ordered by a

Physician or other provider who is an employee or representative of a ~~f~~Free~~-~~standing Facility or diagnostic Hospital-based ~~diagnostic f~~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

[Applies when plan design does not include benefits for infertility treatment.]

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.]

[Applies when plan design includes benefits for infertility treatment.]

[The following infertility treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials.
- Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Donor services.]

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

[Applies when plan design does not include benefits for infertility treatment.]

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

[4.] The reversal of voluntary sterilization [and voluntary sterilization].

[5.] [Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [Contraceptive supplies and services.]

[Will not apply when plan design includes benefits for infertility treatment.]

[7.] [Fetal reduction surgery.]

[8.] [Maternity related medical services for Enrolled Dependent children.]

~~P~~O. Services Provided under another Plan

[Applies when plan design does not include benefits for 24 hour coverage.]

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.]

[Applies when plan design includes benefits for 24 hour coverage.]

[Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, ~~no-fault auto insurance,~~ or similar legislation. This exclusion does not apply to

Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy

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

~~3~~4. Health services while on active military duty.

~~Q. Substance Use Disorders~~

~~**Except as law mandates:**~~

~~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 Use Disorder Services* in *Section 1: Covered Health Services.*~~

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

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

~~3. Educational 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 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:~~

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

~~R~~P. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

[Applies to Network-only plans and to plans with Network and Non-Network benefits when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.]

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

~~S~~Q. Travel

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

[2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed ~~at our discretion~~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~~R. 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~~S. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

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

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

[4.] [Eye exercise or vision therapy.]

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

[Applies when plan design provides benefits for hearing aids.]

[6.] [Bone anchored hearing aids except when either of the following applies:

- For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.]

[Applies when plan design does not provide benefits for hearing aids.]

[6.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

~~V~~T. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and~~,~~ immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of school, sports or camp[, travel,] [career or employment,] insurance, marriage, [Domestic Partnership,] legal partnership 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 the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance ~~and/or~~ any deductible, or other amount owed 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. Examination and Autopsy (physical examinations) except when we request it and cover it at our own expense shall have the right and opportunity to examine the Covered Person when and as often as it may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.
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

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

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

[Applies when plan design includes Medicare estimating.]

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Part A, Part B and Part D] [Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

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

[Eligible Persons must reside within the United States.]

[If both spouses [,Domestic Partner] or legal partner are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

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

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

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

[Applies when the Incentives for Health Rider is sold.]

[During this Initial Enrollment Period, the Enrolling Group will offer an incentive plan as described in the [*Incentives for Health*] Rider which is attached to this *Certificate*. In order to enroll in the [*Incentives for Health*] [in subsequent years] you must meet the eligibility requirements stated in the Rider.]

[Open Enrollment Period]

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

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage, legal partnership [, Domestic Partnership].
- Legal guardianship.
- Court or administrative order.
- [Registering a Domestic Partner.]

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Coverage for newborn children begins at the moment of birth and includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. We must receive notification and any required Premium with 31 days of the birth to have coverage continue beyond that 31-day period.

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage, legal partnership [, Domestic Partnership].
- [Registering a Domestic Partner.]

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

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. [Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.]

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). [Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.]

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

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

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

[Throughout this section, select appropriate option for "date" or "last day of the calendar month in which".]

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Other Events Ending Your Coverage

When the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

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

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

  During the first three years the Policy is in effect, 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. After the first three years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

Coverage for a Disabled Dependent Child

Coverage for an unmarried, [not in a Domestic Partnership or] not in a legal partnership 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 Subscriber for support.

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

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

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

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

[Extended Coverage for Total Disability]

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

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

Continuation of Coverage and Conversion

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

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

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

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

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

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

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

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

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

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, ~~in our discretion~~as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name 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]]

~~[Name of Pharmacy Benefit Manager]~~

~~[Address of Pharmacy Benefit Manager]~~

~~[City, State and Zip Code]]~~

Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days

after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. 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 from the time proof is otherwise required.

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.

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 at the address listed on the back of the Covered Person's ID card or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Payment of Benefits

[Applies when assignment of benefits is agreed to.]

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

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

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

[Applies when assignment of benefits is not agreed to.]

[You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, ~~in our discretion~~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 the 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.]
- Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

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

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

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

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

You may also contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process.

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

A Covered Person may also contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

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

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

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

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

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

Grievance and Appeals Process

If you are dissatisfied with the resolution reached through our internal grievance system regarding Medical Necessity, you may contact the:

Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:

District of Columbia Department of Health Care Finance

Office of the Health Care Ombudsman and Bill of Rights

899 North Capital Street, N.E.

6th Floor,

Washington, D.C. 20002

(877)685-6391

Fax: (202) 478-1397

If you are dissatisfied with the resolution reached through our internal grievance system regarding all other grievances, you may contact the *Commissioner* at the following:

For Non-Medical Necessity cases:

Attention: Commissioner

Department of Insurance, Securities and Banking

810 First St. N.E., 7th Floor

Washington, D.C. 20002

202-727-8000

Fax: (202) 354-1085

Urgent Appeals that Require Immediate Action

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

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

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

Federal External Review Program

If~~, after exhausting your internal appeals,~~ you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination.

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

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

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received our decision.

An external review request should include all of the following:

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

An external review will be performed by an *Independent Review Organization (IRO).* We have entered into agreements with three or more *IROs* that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO.*

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

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

After we complete the preliminary review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating claims assignments among the *IROs* or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the *IRO* within ten business days following the date of receipt of the notice additional information that the *IRO* will consider when conducting the external review. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

Upon receipt of a *Final External Review Decision* reversing our determination, we will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* is that payment or referral will not be made, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

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

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

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

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

After we complete the review, we will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IRO*s. We will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned *IRO* will provide written confirmation of the decision to you and to us.

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

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

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

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

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

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

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

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse, [Domestic Partner] or legal partner does, that parent's spouse, [Domestic Partner] or legal partner's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse, [Domestic Partner] or legal partner.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse, [Domestic Partner] or legal partner.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person ~~as an employee, member, policyholder, subscriber or retiree~~the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

[Applies when plan design includes Medicare estimating.]

[C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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

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

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

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

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

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may, ~~in our discretion~~as we determine, treat the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.]

Right to Receive and Release Needed Information

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

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

Payments Made

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

Right of Recovery

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

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

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

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

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

Our Relationship with Providers and Enrolling Groups

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

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

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

The Enrolling Group is solely responsible for all of the following:

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

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

Your Relationship with Providers and Enrolling Groups

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

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

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

Notice

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

Statements by Enrolling Group or Subscriber

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

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, enhanced Benefits, or other incentives to encourage you to participate in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about

whether or not to participate in a program is yours alone. However, we recommend that you discuss participating in such programs with your Physician. Contact us if you have any questions.~~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

[[1]Include if rebates are not passed on to the Covered Person. [2]Include if rebates are passed on to the Covered Person.]

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. [[1]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.] [[2]We pass these rebates on to you, and they are applied to any deductible and taken into account in determining your Copayments or Coinsurance.]

Interpretation of Benefits

We have the ~~discretion~~ final authority to do all of the following:

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

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

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

Amendments to the Policy

To the extent permitted by law, we reserve the right, ~~in our discretion~~as we determine and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

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

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

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.

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

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

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

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

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

[Applies when plan design includes Medicare estimating.]

[Medicare Eligibility]

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were

covered under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

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

Subrogation and Reimbursement

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

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

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

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

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the final authority ~~and discretion~~ to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

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

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

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part,

future Benefits for the Covered Person that are payable under the Policy. If the refund is due from a person or organization other than the Covered Person, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

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

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

Limitation of Action

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

Entire Policy

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

Section 9: Defined Terms

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

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

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

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

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

[Applies when plan design includes benefits for infertility services.]

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

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 the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

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

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the ~~*Pharmaceutical Product List*~~ *PDLManagement Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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.

[For Pharmaceutical Products, your Copayment is determined by the tier to which the ~~*Pharmaceutical Product List*~~ *PDLManagement Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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

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

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

Covered Person - means the Insured and the following persons (if family coverage is chosen), provided coverage has become effective:

The insured's legal spouse; or a party who, with the insured, has entered into a civil union, recognized under District of Columbia law; [or partners in same-sex relationships or Domestic Partnership from other jurisdictions that provide substantially all of the rights and benefits of marriage]; and each of the insured's dependent children (including stepchildren, foster children, those born to or legally adopted and those during any waiting period prior to the finalization of proposed adoption by either the insured or the insured's legal spouse, or the insured's civil union partner [or other partner in the same-sex relationship from another jurisdiction that provides substantially all of the rights and benefits of marriage.] A Dependent includes an unmarried, [not in a Domestic Partnership or] not in a legal partnership child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

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.

[Options related to dependent eligibility are variable based upon the group's benefit plan eligibility rules.]

Dependent - the Subscriber's legal spouse, [Domestic Partner,] legal partner or a child of the Subscriber or the Subscriber's spouse, [Domestic Partner] or legal partner. [All references to the spouse of a Subscriber shall include a [Domestic Partner or] legal partner, except for the purpose of coordinating Benefits with Medicare.] The term child includes any of the following:

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

[The definition of Dependent also includes:

- [Parents of the Subscriber [or the Subscriber's spouse].]
- [Grandparents of the Subscriber [or the Subscriber's spouse.]
- [Any other sponsored Dependents as agreed upon by us and the Enrolling Group].]
- ~~A natural child.~~
- ~~A stepchild.~~
- ~~A legally adopted child.~~
- ~~A child placed for adoption.~~
- ~~A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.~~
- ~~A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse, [Domestic Partner] or legal partner.~~

~~[The definition of Dependent also includes parents [and grandparents] of the Subscriber [or the Subscriber's spouse, [Domestic Partner] or legal partner] [or such other sponsored Dependents as agreed upon by us and the Enrolling Group].]~~

~~[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]~~

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

- A Dependent includes any child listed above under [26 - 30] years of age.
- A Dependent includes an unmarried, not in a [Domestic Partnership or] legal partnership dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the [month] [year] following the date the child reaches age [26 - 30].]

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

A Dependent includes a minor grandchild, niece, or nephew of the Subscriber if the legal guardian is not covered under insurance. To be eligible for coverage under the Policy, the Subscriber must provide food, clothing, and shelter on a regular and continuous basis for the minor during the time that the District of Columbia public schools are in regular session.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

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

[Designated 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 your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

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

determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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

[Include when Virtual Visits are a standard benefit in Section 1.]

[Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Services via interactive audio and video modalities.]

This is an elective by the employer.

[Domestic Partner - an unmarried, same or opposite sex adult who resides with the Covered Person and has registered in a state or local domestic partner registry with the Covered Person; or your company's requirements.**]**

This is an elective by the employer.

[Domestic Partnership - an unmarried same or opposite sex person who resides with the Subscriber and has registered in a state or local domestic partner registry with a Covered Person, or all of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 16 years of age.
- They must be mentally competent to consent to contract.]

[[1]Applies if group requires documentation of financial interdependence.] This is determined by employer.

- They must be financially interdependent [[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - [They have a single dedicated relationship of at least [6 - 18] months duration.]
  - [They have joint ownership of a residence.]
  - [They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will and/or life insurance policies which designates the other as primary beneficiary].]

[[2]Include if group requires signed affidavit.]

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

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

- Can withstand repeated use.
- Is not disposable.

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

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

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

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

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [An Eligible Person must reside within the United States.]

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity that a person would reasonably expect the absence of immediate medical attention to result in a condition that placed the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or unborn child.

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

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

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

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-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, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

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

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

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

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

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

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

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

Intensive Outpatient Treatment - a structured outpatient mental health or substance-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.]

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, within our discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-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.

The fact that a Physician may prescribe, authorize or direct a service does not itself make it Medically Necessary or covered by the Policy.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our discretion.

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

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

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

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

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

[Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.]

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change.]

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 [by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the

provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

[Applies when plan design does not include benefits for new pharmaceutical products.]

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

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

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

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

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

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

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

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

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

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

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

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

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy - includes all of the following:

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

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

[[1]Applies when OB/GYN Physicians are considered Primary Physicians.]

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, [[1]obstetrics/gynecology,] family practice or general medicine.

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

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

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

[Include this statement when any of these Riders are issued as part of the medical plan. Do not include if those products are being sold as stand-alone products or if outpatient prescription drugs have been carved out of the medical plan.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. [(Note that Benefits for [Outpatient Prescription Drugs][,] [and] [Pediatric Vision Care Services] [and] [Pediatric Dental Services], while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.] Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

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.

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change.]

[[Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Savings Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.]

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

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

[[1]Applies when OB/GYN Physicians are considered Primary Physicians.]

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, [[1]obstetrics/gynecology,] family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-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.

[Applies when group purchases extended coverage for total disability.]

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

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

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

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

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

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

Please note:

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

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

UnitedHealthcare Insurance Company

[Catalyst] [Catalyst Choice] Rider

[NOTE: This Rider supports both Catalyst and Catalyst Choice Products. Product names name filed as variable to allow name change in future.]

This Rider to the Policy provides a limited amount of Benefits that you can access prior to meeting the Annual Deductible requirement stated in the *Schedule of Benefits*. [[Catalyst] [Catalyst Choice] Rider Benefits are available only to [the Subscriber] [Enrolled Dependents] and any reference to "you" in this Rider is a reference to [the Subscriber] [Enrolled Dependents].]

[Catalyst] [Catalyst Choice] Rider Benefits

[Calendar year or Policy year are variable by plan design.]

[Catalyst] [Catalyst Choice] Rider Benefits are available to you on a [calendar] [Policy] year basis.

[Designated network benefit provision is variable by plan design.]

[Non-network benefit provision is variable by plan design.]

[[1]Include only when these services will have a separate annual maximum from other Rider benefits.]

[[2]Include when preventive routine care services are included along with ambulance and emergency in the separate annual maximum.]

We will pay $[50 - 5,000] in [Catalyst] [Catalyst Choice] Benefits per Covered Person in a single year for Covered Health Services identified below that are received from a [Designated Network] [,] [or] Network [or non-Network] provider before you are responsible for meeting the Annual Deductible stated in the *Schedule of Benefits*. [The total amount of [Catalyst] [Catalyst Choice] Rider Benefits is further limited to $[100 - 10,000] in a single year for all Covered Persons in a family.] [[1]**Ambulance Services** and **Emergency Health Services - Outpatient** [[2]and **Preventive Care Services** routine care services] are not included in this annual maximum, but are instead subject to a separate maximum. [[2]Routine care services are Covered Health Services described under the following Benefit categories: **Lab, X-Ray and Diagnostics - Outpatient, Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services, Physician's Office Services - Sickness and Injury, Substance Use Disorder Services and Urgent Care Center Services**]. We will pay $[100 - 7,000] per Covered Person per year in [Catalyst] [Catalyst Choice] Rider Benefits for any combination of **Ambulance Services** and **Emergency Health Services - Outpatient** described below [[2]and we will pay [$50 - 5,000] per Covered Person per year in [Catalyst Choice] Rider Benefits for **Preventive Care** Rider Benefits for routine care services. Routine care services are limited to the Covered Health Services described under the following Benefit categories: **Lab, X-Ray and Diagnostics - Outpatient, Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services, Physician's Office Services - Sickness and Injury, Substance Use Disorder Services and Urgent Care Center Services**].]

After [Catalyst] [Catalyst Choice] Rider Benefits have been exhausted, you must then meet the Annual Deductible before we begin to pay Benefits as described in the *Schedule of Benefits*.

[Copayments/coinsurance applicability toward the annual deductible is variable by plan design.]

The amount that you pay for [Catalyst] [Catalyst Choice] Rider Benefits in Copayments or Coinsurance will [not] be applied toward the Annual Deductible stated in the *Schedule of Benefits.*

The amount that you pay for [Catalyst] [Catalyst Choice] Rider Benefits in Copayments and Coinsurance will [not] be applied toward the Out-of-Pocket Maximum stated in the *Schedule of Benefits*; however Coinsurance paid for [Catalyst] [Catalyst Choice] Rider Benefits will be applied to the Out-of-Pocket Maximum.

~~If you meet the Out-of-Pocket Maximum stated in the *Schedule of Benefits* before reaching your [Catalyst] [Catalyst Choice] Rider Benefit limits, you will continue to pay Copayments or Coinsurance for [Catalyst] [Catalyst Choice] Rider Benefits.~~

~~*[Include when the underlying medical plan has an annual maximum benefit. Including rider benefits in the annual maximum benefit is variable by plan design.]*~~

~~[The amount that we pay for [Catalyst] [Catalyst Choice] Rider Benefits is [not] included in any Annual Maximum Benefit stated in the *Schedule of Benefits.]*~~

Benefits for Covered Health Services that are subject to day or visit limits as stated in the *Schedule of Benefits* are reduced by any days or visits paid as ~~[~~Catalyst~~] [Catalyst Choice]~~ Rider Benefits. Benefits for Covered Health Services that are subject to dollar limits as stated in the *Schedule of Benefits* are not reduced by any dollars paid as ~~[~~Catalyst~~] [Catalyst Choice]~~ Rider Benefits.

Covered Health Services to which ~~[~~Catalyst~~] [Catalyst Choice]~~ Rider Benefits apply are listed below and are described in *Section 1: Covered Health Services* of the *Certificate of Coverage.*

[Include service categories and benefit statements to support plan design.]

[Ambulance Services]

[[1]Include when plan includes non-network benefits. Delete if issued with a network only plan.]

[Emergency Ambulance]

[We will pay Benefits as stated in the *Schedule of Benefits* for either ground or air ambulance. [[1]Benefits for Emergency ambulance services by a non-Network provider are payable as Network Benefits.]]

[[2]Include as applicable when plan design for any non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[Non-Emergency Ambulance]

[We will pay Benefits as stated in the *Schedule of Benefits* for either ground or air ambulance.]

[~~[1]~~[2]Benefits for non-Emergency ambulance services by a non-Network provider are payable as Network Benefits.]

[[2]For Non-Network Benefits for non-Emergency ambulance services, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits for non-Emergency ambulance services, Non-Network Benefits are not available.]

[Clinical Trials]

[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 Rider.]

[Congenital Heart Disease Surgeries]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Dental Services - Accident Only]

[[1]Include when plan includes non-network benefits. Delete if issued with a network only plan.]

[We will pay Benefits as stated in the *Schedule of Benefits*. [[1]Benefits for services by a non-Network provider are payable as Network Benefits.]]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.[3]Non-network benefit are payable as network benefits.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[3]Benefits for services by a non-Network provider are payable as Network Benefits.]]

[Diabetes Services]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Durable Medical Equipment]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Emergency Health Services - Outpatient]

[1Include if plan design supports applying a copayment or coinsurance different from the underlying plan.]

[2Include if plan design supports applying a copayment.]

[3Include if the copayment will be waived if admitted directly from the ER.]

[4Include if plan design is based on the underlying plan.]

[5Include when plan includes non-network benefits. Delete if issued with a network only plan.]

[[1We will pay [50 - 100]% of Eligible Expenses [2after you pay a Copayment of $[5 - 300] per visit [however if the Emergency Health Service is a Mental Health or Substance Use Disorder Emergency Health Service, we will pay 100% of Eligible Expenses]. [3If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [4We will pay Benefits as stated in the *Schedule of Benefits*.] [5Benefits for Emergency Health Services by a non-Network provider are payable as Network Benefits.]]

[Hearing Aids]

[1Include when the plan design is based on the underlying plan.]

[1We will pay Benefits as stated in the *Schedule of Benefits*.]

[2Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[2For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[2For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[2For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[2For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[2For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[2For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[2Non-Network Benefits are not available.]

[Home Health Care]

[1Include when the plan design is based on the underlying plan.]

[1We will pay Benefits as stated in the *Schedule of Benefits*.]

[2Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[2For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[2For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[2For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[2For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[2For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[2For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Hospice Care]

[1Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Hospital - Inpatient Stay]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Lab, X-Ray and Diagnostics - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Designated Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

[[2]Non-Network Benefits are not available.]

[Mental Health Services]

[Inpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]Include if plan design supports applying separate individual/group copayments.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]]

[[4]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[Neurobiological Disorders - Autism Spectrum Disorders]

[Inpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]Include if plan design supports applying separate individual/group copayments.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]]

[[4]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[Ostomy Supplies]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[Pharmaceutical Products - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[Physician Fees for Surgical and Medical Services]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Physician's Office Services - Sickness and Injury]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]Include if plan design supports applying a split copayment.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]

[[5]Include when covered health services performed in a physician's office are subject to the copayments/coinsurance stated under other benefit categories, in addition to the office visit copayment stated in this section. (This will not apply when the office visit benefit is subject to coinsurance only.)]

[[5]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 [and Manipulative Treatment]*.]]

[Pregnancy - Maternity Services]

[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 Rider.]

~~*Because network preventive care must be covered at 100%, include this category only to describe the non-network benefit level. If non-network benefits are not available, delete category completely.*~~

~~**[Preventive Care Services]**~~

~~***[Physician office services]***~~

~~[[1]*Include when the plan design is based on the underlying plan.]*~~

~~[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]~~

~~[[2]*Include as applicable when plan design for the non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan.* [3]*Include if plan design supports applying a copayment.]*~~

~~[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]~~

~~***[Lab, X-ray or other preventive tests]***~~

~~[[1]*Include when the plan design is based on the underlying plan.]*~~

~~[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]~~

~~[[2]*Include as applicable when plan design for the non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan.* [3]*Include if plan design supports applying a copayment.]*~~

~~[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per service].]~~

[Prosthetic Devices]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]Non-Network Benefits are not available.]

[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 Rider.]

[Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when Plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]~~Include if plan design supports applying a split copayment.~~]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] ~~[[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]~~

~~[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.].~~]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

~~[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit].]~~[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]

[[2]Non-Network Benefits are not available.]

[Scopic Procedures - Outpatient Diagnostic and Therapeutic]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Skilled Nursing Facility/Inpatient Rehabilitation Facility Services]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Substance Use Disorder Services]

[Inpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment. [4]Include if plan design supports applying separate individual/group copayments.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 100] per visit]

[[4]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.]

[Surgery - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Therapeutic Treatments - Outpatient]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design for any designated network, network or non-network level of benefits supports applying a coinsurance different from the underlying plan.]

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Transplantation Services]

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design does not include a non-network level of benefits.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Non-Network Benefits are not available.]

[Urgent Care Center Services]

[[1]Include when rider benefits apply only to network benefits and if plan design supports applying a copayment or coinsurance different from the underlying plan. [2]Include if plan design supports applying a copayment.]

[[1]We will pay [50 - 100]% of Eligible Expenses [[2]after you pay a Copayment of $[5 - 150] per visit].]

[[3]Include when rider benefits apply to both network and non-network benefits and if plan design supports applying a copayment or coinsurance different from the underlying plan.]

[[4]Include when plan includes non-network benefits. Delete if issued with a network only plan.]

[[3]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[2]after you pay a Copayment of $[5 - 150] per visit]. [[4]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[4]after you pay a Copayment of $[5 - 150] per visit].]]

[[4]Include when the plan design is based on the underlying plan.]

[[4]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[5]Include when covered health services performed in an urgent care center are subject to the copayments/coinsurance stated under other benefit categories, in addition to the urgent care copayment stated in this section. (This will not apply when the urgent care center benefit is subject to coinsurance only.)]

[[5]In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:

- [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*.]

[~~*[1]Include bracketed reference to Manipulative Treatment when Manipulative Treatment benefits are sold.]*~~**Virtual Visits]**

- ~~[Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment].*]]~~

~~**[Vision Examinations]**~~

[[1]Include when the plan design is based on the underlying plan.]

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]Include as applicable when plan design ~~*for any network or*~~*does not include a non-network level of benefits* ~~*supports applying a copayment or coinsurance different from the underlying plan. [3]Include if plan design supports applying a copayment.]*~~*.]*

~~[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]~~

~~[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]~~

~~[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]~~

~~[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]~~

[3 *Include when non-network benefits for vision exams are not available under the underlying plan.]*

[32For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[2Non-Network Benefits are not available.]

[1Include when first dollar benefits are limited both per person and per family. This option is available only when rider benefits are available to all covered persons.]

[Catalyst] [Catalyst Choice] Rider Benefits apply only to the current year. If you [1or all Covered Persons in your family] do not use the total amount of [Catalyst] [Catalyst Choice] Rider Benefits available in a single year, the remaining amount of [Catalyst] [Catalyst Choice] Rider Benefits will not be carried over to the next year.

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(Name and Title)

Document comparison by Workshare Compare on Wednesday, November 09, 2016 10:23:00 PM

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Document 1 ID	file://\\nas02082pn\data3\LGL\Esther Drew\Product-Mandate Filings\DC\2017 Filings\Large Group\UHIC\Drafting\2016 Approved\Rider-INS-2011-Catalyst Catalyst Choice.doc
Description	Rider-INS-2011-Catalyst Catalyst Choice
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Rendering set	Standard

Legend:	
Insertion	
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Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	77
Deletions	66
Moved from	5
Moved to	5
Style change	0
Format changed	0
Total changes	153

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

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(Name and Title)

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [notification] [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.

[[1]Applies when plan design includes the mandatory or restrictive generic program.]

[[2]Applies when plan design includes a therapeutic class charge.]

[[3]Applies when plan design includes a therapeutically equivalent charge.]

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, [[1]Ancillary Charge,] [[2]Therapeutic Class Charge,] [[3]Therapeutically Equivalent Charge,] and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

~~[Name of Pharmacy Benefit Manager]~~

~~[Address of Pharmacy Benefit Manager]~~

~~[City, State and Zip Code]~~

[Applies when plan design includes the designated pharmacy program. [1]*Applies when plan design includes the specialty drug program.]*

[Designated Pharmacies]

[If you require certain Prescription Drug Products[1], including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

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

[Smart Fill Program - Split Fill]
[Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Smart Fill Program - 90 Day Supply]
[Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

[Variable provision below supports plan designs that include an annual drug deductible or a specialty prescription drug annual deductible and plan designs that are combined medical/RX plans.]

[[1]Applies when rebates are passed on to customers.]

[[2]Applies when rebates are not passed on to customers.]

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] [or] [Specialty Prescription Drug Product Annual Deductible]]. [[1]We pass [a portion of] [all of] these rebates on to you and they may be [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [and] taken into account in determining your Copayments and/or Coinsurance, or may be shared with you at point of service or in another manner.] [[2]We do not pass these rebates on to you, nor are they [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined

medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [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 Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. ~~Pharmaceutical manufacturers~~In some instances, ~~or other~~ non-UnitedHealthcare entities may ~~pay for~~support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or 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.

Include only when benefits for mail order are sold.

[Maintenance Medication Program]

[If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program ~~each year~~ through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.]

[Applies when Rider is issued with combined medical and pharmacy deductible plans and when incentive programs apply.]

[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 *Certificate*, 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.]

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents that are provided under *Pharmaceutical Products – Outpatient* in your Certificate of Coverage, regardless of tier placement.

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.

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Section 1: Benefits for Prescription Drug Products

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

[Benefits for contraceptives are variable by plan design.]

[[1]Applies to plan designs that include closed-panel benefits.]

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]. [[1]Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Include when "Refill Too Soon" program applies.

[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.

[Applies to plan designs that include designated pharmacy.]

[If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

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

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

[Applies to plan designs that include mail order.]

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

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

Section 2: Exclusions

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

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

[Variable exclusions below are plan design-specific.]

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.

[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] [Mental Illness] arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

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

[10.] A Pharmaceutical Product for which Benefits are provided in your *Certificate*. [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [This exclusion does not apply to immunizations administered in a [Network] [or] [a Designated] Pharmacy.]

[11.] Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

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

[13.] Unit dose packaging or repackagers of Prescription Drug Products.

[14.] Medications used for cosmetic purposes.

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

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

[17.] [Prescription Drug Products when prescribed to treat infertility.]

[18.] [Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]

[19.] [Treatment for toenail Onychomycosis (toenail fungus).]

[[1]Include for groups not subject to any essential health benefits requirements that purchase benefits for only certain smoking cessation products.]

[20.] [[[1]Certain] Prescription Drug Products for smoking cessation.]

[Include for groups subject to any essential health benefits requirements that are required to cover smoking cessation drugs in order to be PPACA compliant.]

[20.] [Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.]

[Applies when plan design includes closed benefit.]

[21.] [Prescription Drug Products not included on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or] [Tier 5] 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.]

[Applies when plan design includes closed-panel.]

[22]. [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]

[[1]Applies when plan design includes compounds. [2]Applies when plan design excludes compounds.]

[23.] [[1]Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier [2] [3] [4] [5] [6].)] [[2]Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

[[1]Include when a prescription order/refill is required for coverage. [2]Include if group purchases benefits for smoking cessation that include over-the-counter drugs.]

[24.] [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 [[1]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. [[2]This exclusion does not apply to over-the-counter drugs used for smoking cessation.]]

[25.] [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.]

[[1]Applies when plan design excludes growth hormone therapy for all conditions. [2]Applies when plan design includes limited benefits for growth hormone therapy.]

[26.] [[1]Growth hormone therapy.] [[2]Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]

[27.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

[28.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[29.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

[30.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

[31.] [Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.]

[32.] [Prescription Drug Products when prescribed as sleep aids.]

[33.] [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.]

[34.] [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.]

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

[3~~5~~6.] Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

[37~~6~~.] [A Prescription Drug Product that contains marijuana, including medical marijuana.]

[Include only for groups subject to PPACA essential health benefit benchmark requirements.]

[38~~7~~.] [Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable *United States Pharmacopeia* category and class or applicable state benchmark plan category and class.]

[Exclusion does not apply for grandfathered plans]

[39~~8~~.] [Dental products, including but not limited to prescription fluoride topicals.]

[40.] A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

[41.] Diagnostic kits and products.

[42.] Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

[Variable definitions below are plan design-specific.]

[Applies to plan designs that include the mandatory or restrictive generic program.]

[[1]Applies to the mandatory generic program.]

[**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 [[1]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 Drug Deductible** - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] 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.]

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, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

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

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

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, data sources such as medi-span or 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.

[Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[**Infertility Annual Maximum Benefit -** the maximum amount we will pay for covered Prescription Drug Products for Infertility during a year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Annual Maximum Benefit applies.]

[**Infertility Maximum Policy Benefit -** the maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Maximum Policy Benefit applies.]

[[1]Include when plan design includes specialty prescription drug program]

[**List of Preventive Medications -** a list that identifies certain Prescription Drug Products [[1], which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to

reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include only when benefits for mail order are sold.

[Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at [ww.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our periodic review and modification and varies by Therapeutic Class.]

[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.]

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 Mail Order Network Pharmacy - a mail order pharmacy that we identify as a non-preferred pharmacy within the Network.]

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

[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.]

[Preferred Mail Order Network Pharmacy - a mail order pharmacy that we identify as a preferred pharmacy within the Network.]

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

[Applies when plan design includes mail order and MAC pricing.]

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. [The Prescription Drug Charge for a Generic Prescription Drug Product dispensed by a mail order Network Pharmacy, however, will be the Maximum Allowable Cost (MAC) List price which may be higher or lower than the rate we have agreed to pay the mail order Network Pharmacy. We establish the Maximum Allowable Cost (MAC) List price. You may access the amount you will pay for a Brand-name or Generic Prescription Drug Product to be dispensed by a retail Network Pharmacy and/or a mail order Network Pharmacy through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Depending upon your plan design, the amount you will pay may be a Copayment, Coinsurance or the Prescription Drug Charge.]

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~~,~~ or 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.
- [Immunizations administered in a pharmacy.]
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors. [This does not include continuous glucose monitors.]

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice 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 Prescription Drug Charge] [the cost] (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

[Applies if immunizations are covered under the pharmacy benefit:]

- [Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.]
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.]

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

[**Specialty Prescription Drug Product -** Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [Specialty Prescription Drug Products include certain drugs for Infertility.] [Specialty Prescription Drug Products may include

drugs on the List of Preventive Medications.] 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.]

[**Specialty Prescription Drug Product Annual Deductible** - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Specialty Prescription Drug Products in a year before we begin paying for Specialty Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Annual Deductible applies.]

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

[**Therapeutic Class -** a group or category of Prescription Drug Products with similar uses and/or actions.]

[**Therapeutic Class Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class.]

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

[**Therapeutically Equivalent Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is Therapeutically Equivalent to a Prescription Drug Product where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product.]

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.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

_____

(Name and Title)

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [notification] [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.

[[1]Applies when plan design includes the mandatory or restrictive generic program.]

[[2]Applies when plan design includes a therapeutic class charge.]

[[3]Applies when plan design includes a therapeutically equivalent charge.]

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, [[1]Ancillary Charge,] [[2]Therapeutic Class Charge,] [[3]Therapeutically Equivalent Charge,] and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Spring, AR 71903

~~[Name of Pharmacy Benefit Manager]~~

~~[Address of Pharmacy Benefit Manager]~~

~~[City, State and Zip Code]~~

[Applies when plan design includes the designated pharmacy program. [1]*Applies when plan design includes the specialty drug program.]*

[Designated Pharmacies]

[If you require certain Prescription Drug Products[1], including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

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

[Smart Fill Program - Split Fill]
[Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Smart Fill Program - 90 Day Supply]
[Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

[Variable provision below supports plan designs that include an annual drug deductible or a specialty prescription drug annual deductible and plan designs that are combined medical/RX plans.]

[[1]Applies when rebates are passed on to customers.]

[[2]Applies when rebates are not passed on to customers.]

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] [or] [Specialty Prescription Drug Product Annual Deductible]]. [[1]We pass [a portion of] [all of] these rebates on to you and they may be [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [and] taken into account in determining your Copayments and/or Coinsurance, or may be shared with you at point of service or in another manner.] [[2]We do not pass these rebates on to you, nor are they [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined

medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [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 Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. ~~Pharmaceutical manufacturers~~In some instances, ~~or other~~ non-UnitedHealthcare entities may ~~pay for~~support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or 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.

Include only when benefits for mail order are sold.

[Maintenance Medication Program]

[If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program ~~each year~~ through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.]

[Applies when Rider is issued with combined medical and pharmacy deductible plans and when incentive programs apply.]

[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 *Certificate*, 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.]

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents that are provided under *Pharmaceutical Products – Outpatient* in your Certificate of Coverage, regardless of tier placement.

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.

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Section 1: Benefits for Prescription Drug Products

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

[Benefits for contraceptives are variable by plan design.]

[[1]Applies to plan designs that include closed-panel benefits.]

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]. [[1]Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Include when "Refill Too Soon" program applies.

[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.

[Applies to plan designs that include designated pharmacy.]

[If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

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

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

[Applies to plan designs that include mail order.]

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

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

Section 2: Exclusions

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

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

[Variable exclusions below are plan design-specific.]

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.

[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] [Mental Illness] arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

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

[10.] A Pharmaceutical Product for which Benefits are provided in your *Certificate*. [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [This exclusion does not apply to immunizations administered in a [Network] [or] [a Designated] Pharmacy.]

[11.] Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

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

[13.] Unit dose packaging or repackagers of Prescription Drug Products.

[14.] Medications used for cosmetic purposes.

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

[16.] Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

[17.] [Prescription Drug Products when prescribed to treat infertility.]

[18.] [Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]

[19.] [Treatment for toenail Onychomycosis (toenail fungus).]

[[1]Include for groups not subject to any essential health benefits requirements that purchase benefits for only certain smoking cessation products.]

[20.] [[[1]Certain] Prescription Drug Products for smoking cessation.]

[Include for groups subject to any essential health benefits requirements that are required to cover smoking cessation drugs in order to be PPACA compliant.]

[20.] [Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.]

[Applies when plan design includes closed benefit.]

[21.] [Prescription Drug Products not included on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or] [Tier 5] 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.]

[Applies when plan design includes closed-panel.]

[22]. [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]

[[1]Applies when plan design includes compounds. [2]Applies when plan design excludes compounds.]

[23.] [[1]Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier [2] [3] [4] [5] [6].)] [[2]Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

[[1]Include when a prescription order/refill is required for coverage. [2]Include if group purchases benefits for smoking cessation that include over-the-counter drugs.]

[24.] [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 [[1]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. [[2]This exclusion does not apply to over-the-counter drugs used for smoking cessation.]]

[25.] [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.]

[[1]Applies when plan design excludes growth hormone therapy for all conditions. [2]Applies when plan design includes limited benefits for growth hormone therapy.]

[26.] [[1]Growth hormone therapy.] [[2]Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]

[27.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

[28.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[29.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

[30.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

[31.] [Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.]

[32.] [Prescription Drug Products when prescribed as sleep aids.]

[33.] [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.]

[34.] [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.]

[35.] Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

[3~~5~~6.] Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

[37~~6~~.] [A Prescription Drug Product that contains marijuana, including medical marijuana.]

[Include only for groups subject to PPACA essential health benefit benchmark requirements.]

[38~~7~~.] [Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable *United States Pharmacopeia* category and class or applicable state benchmark plan category and class.]

[Exclusion does not apply for grandfathered plans]

[39~~8~~.] [Dental products, including but not limited to prescription fluoride topicals.]

[40.] A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

[41.] Diagnostic kits and products.

[42.] Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

[Variable definitions below are plan design-specific.]

[Applies to plan designs that include the mandatory or restrictive generic program.]

[[1]Applies to the mandatory generic program.]

[**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 [[1]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 Drug Deductible** - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] 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.]

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, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

[**Designated Pharmacy -** a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products[, including, but not limited to, Specialty Prescription Drug Products]. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.]

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, data sources such as medi-span or 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.

[Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[**Infertility Annual Maximum Benefit -** the maximum amount we will pay for covered Prescription Drug Products for Infertility during a year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Annual Maximum Benefit applies.]

[**Infertility Maximum Policy Benefit -** the maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Maximum Policy Benefit applies.]

[[1]Include when plan design includes specialty prescription drug program]

[**List of Preventive Medications -** a list that identifies certain Prescription Drug Products [[1], which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to

reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include only when benefits for mail order are sold.

[Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at [ww.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our periodic review and modification and varies by Therapeutic Class.]

[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.]

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 Mail Order Network Pharmacy - a mail order pharmacy that we identify as a non-preferred pharmacy within the Network.]

[Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.]

[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.]

[Preferred Mail Order Network Pharmacy - a mail order pharmacy that we identify as a preferred pharmacy within the Network.]

[Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.]

[Applies when plan design includes mail order and MAC pricing.]

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. [The Prescription Drug Charge for a Generic Prescription Drug Product dispensed by a mail order Network Pharmacy, however, will be the Maximum Allowable Cost (MAC) List price which may be higher or lower than the rate we have agreed to pay the mail order Network Pharmacy. We establish the Maximum Allowable Cost (MAC) List price. You may access the amount you will pay for a Brand-name or Generic Prescription Drug Product to be dispensed by a retail Network Pharmacy and/or a mail order Network Pharmacy through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Depending upon your plan design, the amount you will pay may be a Copayment, Coinsurance or the Prescription Drug Charge.]

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~~,~~ or 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.
- [Immunizations administered in a pharmacy.]
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors. [This does not include continuous glucose monitors.]

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice 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 Prescription Drug Charge] [the cost] (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

[Applies if immunizations are covered under the pharmacy benefit:]

- [Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.]
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.]

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[**Specialty Prescription Drug Product -** Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [Specialty Prescription Drug Products include certain drugs for Infertility.] [Specialty Prescription Drug Products may include

drugs on the List of Preventive Medications.] 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.]

[**Specialty Prescription Drug Product Annual Deductible** - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Specialty Prescription Drug Products in a year before we begin paying for Specialty Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Annual Deductible applies.]

[**Specialty Prescription Drug Product Out-of-Pocket Maximum -** the maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Out-of-Pocket Maximum applies.]

[**Therapeutic Class -** a group or category of Prescription Drug Products with similar uses and/or actions.]

[**Therapeutic Class Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class.]

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

[**Therapeutically Equivalent Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is Therapeutically Equivalent to a Prescription Drug Product where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product.]

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.

[This form is filed with variability to support grandfathered and non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the out-of-pocket maximum, including all cost sharing for Essential Health Benefits. Variables included below in the Schedule of Benefits that allow cost shares to be excluded from the network out-of-pocket maximum or to remove the network out-of-pocket maximum can only be utilized for grandfathered plans. Any combination of the deductible variables and any combination of the out-of-pocket maximum variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans. Any variables below that allow the cost shares under the outpatient prescription drug rider to not apply to the out-of-pocket maximum may only be utilized for grandfathered plans, or by non-grandfathered plans that include a separate out-of-pocket drug maximum (which when combined with the medical out-of-pocket maximum may not exceed the annual limitation on cost sharing required under ACA).]

[[1]Product names are variable for possible future product name change]

UnitedHealthcare [[1]Choice Plus] UnitedHealthcare of the Mid-Atlantic, Inc. ~~and UnitedHealthcare Insurance Company~~

Schedule of Benefits

Accessing Benefits

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

You can choose to receive [Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[**Designated Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or PCP.

[Select the applicable option(s) and delete the others. *If either Option #1 or #2 is included, you must delete all other options 3, 4, 5 and 6 to support payment methods available prior to Emergent and Non-Emergent ENRP.]*

[[1]Include if non-network RAPLs at a network facility are paid as network benefits.]

[[1]Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[2]Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

[[2]For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.]

[[3]Include and delete #4 if Emergency Health Services provided by a non-Network provider are paid as network benefits, and member hold harmless (Emergent ENRP Option does not apply).]

[[4]Include and delete #3 if Emergency Health Services provided by a non-Network provider are not paid at billed charges (Emergent ENRP Option).]

[[3]Emergency Health Services are always paid as Network Benefits.]

[[4]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.**]

[[5]Include and delete #6 if non-emergent services by non-network RAPLEs at a network facility are paid as network benefits and member hold harmless (Non-Emergent ENRP Option does not apply).]

[[6]Include and delete #5 if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP Option).]

[[5]For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Benefits for non-Emergency Covered Health Services include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[[6]Covered Health Services that are provided at a Network facility 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.**]

[[7]Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as *Out-of-Network Benefits.* [[7]Covered Health Services, when not Emergency Health Services, provided in a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant] will be paid as Non-Network Benefits.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Include when the enhanced benefits for certain procedures/clinical support is sold.]

[You may have an opportunity to received enhanced Benefits for certain procedures received at a Designated Facility and/or by a Designated Physician as described in this *Schedule of Benefits*. You can also determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* the telephone number on your ID card.]

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits***.**

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Prior Authorization

We 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 Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization 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.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* **on your ID card.** This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

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 and ground.
- [Breast pumps.]

- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- [Diabetes equipment - insulin pumps [over $[1,000 - 5,000]].]
- [Durable Medical Equipment [over $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]
- [Habilitative Services.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- ~~[Habilitative Services.]~~
- [Hearing aids [that exceed $[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- [Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.]
- [Lab, X-ray and major diagnostics - CT, PET ~~Scans~~scans, MRI, MRA, ~~Nuclear Medicine and Capsule Endoscopy~~capsule endoscopy and nuclear medicine, including nuclear cardiology.]
- Mental Health Services - inpatient services (including ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility)~~facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility),~~facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*.
- [Obesity surgery.]
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]
- [Prosthetic devices [over $[1,000 - 5,000] in cost per device].]

- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility)~~facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.

[[1]Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

When Benefit limits apply, the limit stated refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
[Annual deductible is plan design variable. Include applicable provisions to support the following: *[1]Annual deductible applies only to non-network benefits.* *[2]Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.* *[3]Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.* *[4]Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.* *[5]Outpatient Prescription Drug Rider is sold, there is a deductible for designated and/or network benefits and the network and non-network amounts apply to the designated network and network annual deductible.* *[6]Include when Designated Network Benefits apply to any benefit category]* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [[1]Non-Network] Benefits. [[2]The Annual Deductible 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 Rider*. [[3]Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[4]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] [[5]The Annual Deductible for [[6]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the *Outpatient Prescription Drug Rider*.] *[Include applicable provisions to support the following:* *[1]Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* *[2]Carry-over provision applies.* *[3]Roll-over provision applies in any circumstance.* *[4]Roll-over provision applies only to groups changing from calendar to policy year. [5]Include when roll-over applies only to the individual deductible.*	*[[1]Include separate network and non-network headings and statements when annual deductible provision applies separately.]* *[[2]Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]* *[[3]Include when designated network and network are separate.]* ***[[1][[2]Designated Network and] Network] [[3]Designated Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[[3]Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated

Payment Term And Description	Amounts
[6Include only when a per occurrence deductible applies.] [1Amounts 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.] [2Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] [3When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] [4When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [5This roll-over feature applies only to the individual 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. [6The Annual Deductible does not include any applicable Per Occurrence Deductible.] *[Applies when cross accumulation applies to Designated Network and Network Annual Deductible]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.]	above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] ***[1Non-Network]*** *[A Non-embedded.]* *[B Embedded.]* [A For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [B $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.] [No Annual Deductible.] *[4Include the combined network and non-network heading and statements when annual deductible provision applies separately to combined network and non-network benefits.* *5Include when designated network benefits apply to any category.]* ***[4[5Designated Network,] Network and Non-Network]*** *[A Non-embedded.]* *[B Embedded.]* [A For single coverage, the Annual Deductible is $[0 - 15,000] ~~per Covered Person~~.

Payment Term And Description	Amounts
	If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] [$[0 - 15,000] per Covered Person.] [[B] $[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
[Per occurrence deductible is plan design variable.] **[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
[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following: *[1]Includes the annual deductible.* *[2]Includes the per occurrence deductible.* *[3]Includes copayments.* *[4]Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.* *[5] Outpatient Prescription Drug Rider is sold, the OOPM applies to designated and/or network benefits and the network and non-network amounts paid under the RX rider apply to the designated network and/or network OOPM.* *[6]Include when Designated Network Benefits apply to any benefit category]* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]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 Rider*.] [[5]The Out-of-Pocket Maximum for [[6]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.] *[Include when plan design does not apply all copayments/coinsurance to the OOPM.]* [[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. *[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]* • [The amount Benefits are reduced if you do not obtain prior authorization as required.] • Charges that exceed Eligible Expenses.	*[[1]Include separate network and non-network headings and statements when OOPM provision applies separately.]* *[[2]Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]* *[[3]Include when designated network and network are separate.]* ***[[1][[2]Designated Network and] Network] [[3]Designated Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For 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. *[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]* • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] *[Applies when cross accumulation applies to Designated Network and Network OOPM]* [Any amount that you pay for Covered Health Services that is applied to the Designated Network Out-of-Pocket Maximum will be applied to the Network Out-of-Pocket Maximum. Any amount you pay for Covered Health Services that is applied to the Network Out-of-Pocket Maximum will be applied to the Designated Network Out-of-Pocket Maximum.]	coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family reaches the overall Out-of-Pocket Maximum of $[0 - 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 - 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]

Payment Term And Description	Amounts
	[No Out-of-Pocket Maximum.] ***[[3]Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] *Include when Uber-MOOP applies.* *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 – 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 – 45,000]. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, once the family has met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 – 135,000], the family will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until the family

Payment Term And Description	Amounts
	reaches the overall Out-of-Pocket Maximum of $[0 – 135,000].] [Once you have met the out-of-pocket expenses for any deductible, Copayment or Coinsurance of $[0 – 45,000], you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 – 45,000].] [[B]Once you have met the out-of-pocket expenses for any deductible, Copayment and Coinsurance of $[0 – 45,000] per Covered Person, not to exceed $[0 – 135,000] for all Covered Persons in a family, you will continue to be responsible for paying Copayments[, except for [Copayments] [and] [Coinsurance] as shown in your *Outpatient Prescription Drug Schedule of Benefits*] [and Per Occurrence Deductibles] until you reach the overall Out-of-Pocket Maximum of $[0 – 45,000] per Covered Person, not to exceed $[0 – 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] ***[[1]Non-Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000]~~ per Covered Person~~. If more than one person in a family is

Payment Term And Description	Amounts
	covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No Out-of-Pocket Maximum.] *[[4]Include combined network and non-network heading and statements below when OOPM provision applies to combined network and non-network benefits and delete the separate "Network" and "Non-Network" provisions above.]* *[[5]Include when designated network benefits apply to any category.]* ***[[A][[5]Designated Network,] Network and Non-Network]*** *[A] Non-embedded.* *[B] Embedded.* [[A] For single coverage, the Out-of-Pocket Maximum is $[0 - 45,000] ~~per Covered Person~~. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 135,000].] [$[0 - 45,000] per Covered Person.] [[B] $[0 - 45,000] per Covered Person, not to exceed $[0 - 135,000] for all

Payment Term And Description	Amounts
	Covered Persons in a family.] [The Out-of-Pocket Maximum includes the Annual Deductible.] [The Out-of-Pocket Maximum does not include the Annual Deductible.] [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] [No 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.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the ~~Pharmaceutical Product~~Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

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.

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the ~~Pharmaceutical Product~~Prescription Drug List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.

- Prior authorization requirements and any penalty for failure to prior authorize

- Designated network benefit levels as applicable.

- Any other specific conditions for coverage described within the category.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
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. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.] [Limited to [10 - 100] treatments per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - 5,000] in Eligible Expenses per year.] [This limit applies to Network Benefits only. Non-Network Benefits are not available.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
	[Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150]	[Yes] [No] [Yes, when Benefits are subject to	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [Non-Network Benefits are not available.]	Coinsurance] [Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
[2.] 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	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] ~~[100% after you pay a Copayment of $[300 - 1,000] per day]~~ ~~[100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]~~ *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] ~~[100% after you pay a Copayment of $[2,500 -~~	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	~~10,000] per day]~~ ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]~~ ***Non-Network*** Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] ~~[100% after you pay a Copayment of $[300 - 1,000] per day]~~ ~~[100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]~~ *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day]~~ ~~[100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]~~ ***Non-Network***	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Ground Ambulance: [[50 - 100]%] [Same as Network] [Non-Network Benefits not available] *Air Ambulance:* [[50 - 100]%] [Same as Network] [Non-Network Benefits not available]	[Yes][No] [Same as Network] [Non-Network Benefits not available] [Yes][No] [Same as Network] [Non-Network Benefits not available]	[Yes][No] [Same as Network] [Non-Network Benefits not available] [Yes][No] [Same as Network] [Non-Network Benefits not available]
[3.] 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.			
	[Designated Network] [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*.]		
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. (Non-Network	***Network*** 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.* ***Non-Network*** 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.*		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
[4.] [Congenital Heart Disease Surgeries]			
[Prior Authorization Requirement] *[Applies for plan designs that do NOT require the use of a designated facility. When included, remove prior authorization requirements below.]* [For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] *[Applies for plan designs that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included remove the prior authorization requirement above.]* [For Covered Health Services required to be ~~performed~~received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not ~~performed~~received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid.] [[2]Network Benefits will apply] [[2]For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Designated Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] [Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]	Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[[1]Applies for plan designs that include Network Benefits only and require the use of designated facility. [[1]For Network Benefits, CHD surgeries must be received at a Designated Facility and performed by a Designated Physician.] *[[1]Applies for plan designs that include designated network and non-network benefits.]* [[1]For Designated Network Benefits, CHD surgeries must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services ~~provided~~received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician. Non-Network Benefits under this section include only the CHD surgery] *[Applies for plan designs that require the use of a designated facility]* [Depending upon where the Covered Health Service is	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]			
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
	[Non-Network]		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[100 - 1,000] per day]	[Non-Network Benefits are not available.]	[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		[Non-Network Benefits are not available.]
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Non-Network Benefits are not available.]		
	[Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
	[Non-Network Benefits are not available.]		
[5.] [Dental Services - Accident Only]			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Prior Authorization Requirement] [For [Designated Network,] Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]
~~[Limited to $[2,000 - 5,000] per year. Benefits are further limited to a maximum of $[500 - 1,500] per tooth.]~~	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] ***[Non-Network]*** [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Same as Network]
[6.] Diabetes Services			
[[1]Include when the durable medical equipment benefit is sold.] *[[2]Include when the durable medical equipment benefit is not sold.]* **Prior Authorization Requirement** For Non-Network Benefits you must obtain prior authorization before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***[Designated Network]*** [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 and Training/Diabetic Eye**~~	***Network*** Depending upon where the Covered Health Service is provided,		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
~~**Examinations/Foot Care**~~	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*. ***Non-Network*** 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 *Include when benefits for durable medical equipment are sold and when state law permits limits on diabetes equipment.* [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.] *[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]* [Benefits for insulin pumps are limited to a single purchase (including repair/replacement) every [[year] [[two-five] years]] [[12 - 60] months].]	***[Designated Network]*** *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	the Out-of-Pocket Maximum.]]		
	Network *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
	Non-Network *[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]* [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*		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Prescription Drug Rider.] *[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]* [For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]* [For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[7.] [Durable Medical Equipment]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds $[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [[year] [two - five] [years]] [[12 - 60] months].] [This limit does not apply to wound	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
vacuums[, which are limited to a single purchase (including repair/replacement) every [[year] [[two - five] years]] [[12 - 60] months]].] [Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every [three years] [36 months]. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.] [Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months]. Speech aid and tracheo-esophageal voice devices are [not] included in the limits stated above.] [To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[8.] Emergency Health Services - Outpatient			
This includes reimbursement for the cost of one annual voluntary HIV screening test performed on the insured while receiving emergency medical services, other than HIV screening, regardless of necessity, per state mandate. This includes reimbursement of the costs of administering such test, all laboratory expenses to analyze the test, and the costs of communicating to the insured the results of the test and any applicable follow-up. This is not subject to any annual or coinsurance deductible or any copayment other than the copayment that the insured would have to pay for the applicable hospital emergency department visit. **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, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. *Include only when emergent ENRP applies.*	***Network*** [[50 - 100]%] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit. [If you are admitted as an inpatient to a Network Hospital directly from the Emergency room you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[50 - ~~650~~700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for the first [2 - 20] visits in	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes, after the Per Occurrence Deductible of $[5 - 700] per visit is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[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.**]	a year; [50 - 100]% after you pay a Copayment of $[50 - ~~650~~700] per visit for the next [2 - 20] visits in a year; [50 - 100]% after you pay a Copayment of $[100 - 700] for any subsequent visits in that year] [[50 - 100]% after you pay a Copayment of $[5 - ~~650~~700] per visit for a condition defined as an Emergency; [50 - 100]% after you pay a Copayment of $[50 - ~~650~~700] per visit for a condition that does not meet the definition of an Emergency] [After you pay a Copayment of $[5 - 700] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** Same as Network	Same as Network	Same as Network
[9.] [Hearing Aids]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization before obtaining a hearing aid [that exceeds $[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to $[500 - 5,000] in Eligible Expenses every [year] [12 months].] [Benefits are [further] limited to a single purchase (including repair/replacement) per	***[Designated Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
hearing impaired ear every [[year] [[two-five] years]] [[12 - 60] months].]	1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***[Non-Network]*** [[50 - 100]%] [After you pay a Copayment of $[50 - 1,000] per device [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	of $[50 - 1,000] per device is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 1,000] per device is satisfied] [Non-Network Benefits are not available.]
[10.] Home Health Care			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 50] per visit is

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
- 200] 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.]	[After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] [After you pay a Copayment of $[5 - 50] per visit [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Stay in a hospice facility.]			
	[Designated Network] [[50 - 100]%] ~~[100% after you pay a Copayment of $[5 - 100] per day]~~ ***Network*** ~~[~~[50 - 100]%~~]~~ ~~[100% after you pay a Copayment of $[5 - 100] per day]~~ ***Non-Network*** ~~[~~[50 - 100]%~~]~~ ~~[100% after you pay a Copayment of $[5 - 100] per day]~~	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[12.] Hospital - Inpatient Stay			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as described below:] • [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures at a Designated Network Facility, your Benefit will be enhanced as described below:] • [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply] [be reduced to $[100 - 1,750].] [The maximum reduction in Copayments is $[10 - 1,000].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 1,000]. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750] [The maximum reduction in Copayments is $[10 - 1,000].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]]			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Without clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 1,750].]] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].] [[For Network Benefits, ventricular] [Ventricular] assist device implantation services must be received at a Designated Facility.]	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[13]. [Infertility Services]			
[Prior Authorization Requirement] *[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization options below.]* [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] *[Required for plans that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included, remove prior authorization option above.]* [For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, and as a result infertility services are not received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid][[2]Network Benefits will apply.] [[2]For [Network and] Non-Network Benefits, you must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50-90]% of Eligible Expenses][you will be responsible for paying all charges and no Benefit will be paid.]			
[Limited to $[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.] [Benefits for Assisted Reproductive Technology (ART) are limited to [one - three]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
procedure[s] during the entire period of time a Covered Person is enrolled under the Policy.] *[[1]Applies to plan designs with Network Benefits only that require the use of designated facility.]* [[1]For Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician.] *[[1]Applies for plan designs that include designated network and non-network benefits]* [[1]For Designated Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services ~~provided~~received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician.]	***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement] [For Non-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Occurrence Deductible of $[5 - 100] per service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding lab [or in a Physician's office]] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office]] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding lab [or in a Physician's office] [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a Hospital-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Hospital-based lab] [After you pay a Copayment of $[5 - 100] per service at a Hospital-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician office-based lab] [100% after you pay a Copayment of $[5 - 100] per service at a Physician office-based lab] [After you pay a Copayment of $[5 - 100] per service at a Physician office-based lab [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
X-Ray and Other Diagnostic Testing - Outpatient	***[Designated Network]***		
	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician's office] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [After you pay a Copayment of $[5 - 100] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 100] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 100] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based diagnostic center] [After you pay a Copayment of $[5 - 100] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
[Prior Authorization Requirement] [For Non-Network Benefits for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office]	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	Occurrence Deductible of $[5 - 850] per service is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 850] per service] [After you pay a Copayment of $[5 - 850] per service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [100% after you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office] [After you pay a Copayment of $[5 - 850] per service at a ~~free-standing~~freestanding diagnostic center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 850] per service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	based diagnostic center] [After you pay a Copayment of $[5 - 850] per service at an outpatient Hospital-based diagnostic center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
[16.] Mental Health Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[Outpatient] [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 – 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense]		
	Outpatient [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[17.] Neurobiological Disorders - Autism Spectrum Disorder Services			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]* [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied] [Yes] [No]
	[[50 - 100]% for Partial	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 - 1,000] per session for Partial		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management] [[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
	Non-Network *Inpatient* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[18.] [Obesity Surgery]			

[Prior Authorization Requirement]

[Applies for plans that do NOT require use of a designated facility. When included remove prior authorization options below.]

[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]

[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]

[Required for plans that require the use of a designated facility. [1]Applies to plan designs that do not include a non-network benefit level. [2]Applies to plan designs that include a designated network benefit level. When included, remove prior authorization option above.]

[For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, and as a result obesity surgery is not received at a Designated Facility and performed by a Designated Physician, [[1]Benefits will not be paid][[2]Network Benefits will apply] [[2]For [Network and] Non-Network Benefits, you must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
surgery arises]. If you fail to obtain prior authorization as required [Benefits will be reduced to [50-95]% of Eligible Expenses][you will be responsible for paying all charges and no Benefits will be paid.] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[[Any combination of] [Designated Network Benefits] [[,] [and] [Network Benefits] [and Non-Network] Benefits [is] [are] limited to $[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. [Non-Network Benefits are further limited to $[5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]] [Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.]	~~*[**Note to Filer:** Designated Network Benefits are never available on plan designs where non-network benefits are not available. Remove instruction prior to filing.]*~~ ***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[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*.]		
[Applies for plan designs with Network Benefits only that require the use of a designated facility.] [For Network Benefits, obesity surgery must be received at a Designated Facility and performed by a Designated Physician.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[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*.]		
[Applies for plan designs that include designated network and non-network benefits.]	***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits	[Yes] [No] [Non-Network Benefits are	[Yes] [No] [Non-Network Benefits are not available.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[For Designated Network Benefits, obesity surgery must be received at a Designated Facility and performed by a Designated Physician. Network Benefits include services ~~provided~~received at a Network facility and performed by a Network Physician that is not a Designated Facility and Designated Physician.]	are not available.] [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*.] [Non-Network Benefits are not available.]	not available.]	
[19.] [Ostomy Supplies]			
[Limited to $[500 - 25,000] per year.]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	 [Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	 [Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]
[20.] Pharmaceutical Products - Outpatient			

[Prior Authorization Requirement]

[For Non-Network Benefits you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]

[For Non-Network Benefits you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
number on your ID card.]			
[The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical 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.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2]	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product] [100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical	[Yes] [No]	[Yes] [No] [Yes, except when provided during a Physician office visit]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] [100% after you pay a Copayment of $[0 - 75] per Tier 1 Pharmaceutical Product] [100% after you pay a Copayment of $[15 - 250] per Tier 2 Pharmaceutical Product] [100% after you pay a Copayment of $[20 - 450] per Tier 3 Pharmaceutical Product] [100% after you pay a Copayment of $[70 - 650] per Tier 4 Pharmaceutical Product] [100% after you pay a Copayment of $[100 - 750] per Tier 5 Pharmaceutical Product]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, except when provided during a Physician office visit] [Non-Network Benefits are not available.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[150 - 850] per Tier 6 Pharmaceutical Product] [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] [Non-Network Benefits are not available.]		
[21.] Physician Fees for Surgical and Medical Services			
Include only when non-emergent ENRP applies. [Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses 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**	***[Designated Network]*** [[50 - 100]%] [[50 - 100]% for Covered Health Services from a Primary Physician] [[50 - 100]% for Covered Health Services from a Specialist Physician] ***Network*** [[50 - 100]%]	 [Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No]	 [Yes] [No] [Yes] [No] [Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
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.] [When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Coinsurance you pay			

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Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] *[Include when the enhanced benefits for certain procedures/clinical support is sold.]* [When you received certain procedures from a Designated Network Physician, your Benefit will be enhanced as described below:] • [With clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] • [Without clinical support, the Coinsurance you pay for Physician's fees for services provided from a Designated Physician will be reduced to [0-50]%.] [You can determine the specific procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a Specialist Physician]	[Yes] [No]	[Yes] [No]
Neither option below will be included with Non-Emergent ENRP.	***Non-Network***		
[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]			
	[[50 - 100]% for Covered Health Services from a Primary Physician]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Covered Health Services from a	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Specialist Physician]		
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] *Include headings when plan design supports separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit]		
	[100% for allergy injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 -150] per visit for any subsequent visits in that year.]	[Yes][No]	[Yes][No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	- 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]		
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[When you choose to seek care from Designated Network Physicians as identified below, your Benefits will be enhanced as	***Network***	[Yes] [No]	[Yes] [No]
	Include headings when plan design supports	[Yes, when Benefits are	[Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a	*separate child copayment feature and insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy	subject to Coinsurance]	[Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	injections when no other service is provided during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	visit for the first [2 - 10] visits in a year.]		
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[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	***Non-Network***	[Yes] [No]	[Yes] [No]
	Include headings when plan design supports separate child copayment feature and	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
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 [*and *Manipulative Treatment]*.]]	*insert beneath each heading the appropriate Benefit, OOPM and Annual Deductible statements.* **[For Covered Persons under the age of [12 - 22]:]** **[For Covered Persons age [12 - 22] and older:]** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit and [50 - 100]% for a Specialist Physician office visit] [100% for allergy injections when no other service is provided		Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	during the office visit]		
	[[50 – 100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 – 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 90]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 75] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% [after you pay a Copayment of $[5	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	- 150]] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.]		
	[[50 - 100]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit for the first [2 - 10] visits in a year.	[Yes] [No]	[Yes] [No]
	[50 - 100]% for any subsequent visits in that year.**]**	[Yes] [No]	[Yes] [No]
[23.] Pregnancy - Maternity Services			

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.

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.

	[Designated Network]
	[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].]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Network 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]. ***Non-Network*** 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].		
[24.] Preventive Care Services			
[Include prior authorization requirement if prior authorization requirements apply. Include penalty statement if a penalty is assessed and select the applicable penalty.] **[Prior Authorization Requirement]** [For Non-Network Benefits, you must obtain prior authorization before obtaining a breast pump. [If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]]			
Physician office services	***Network*** 100% ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician	No [Yes] [No] [Yes, when Benefits are subject to Coinsurance] ~~[Non-Network Benefits are not available.]~~	No [Yes] [No] [Yes, when Benefits are subject to Coinsurance] ~~[Non-Network Benefits are not available.]~~

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% for immunizations when no other service is provided during the office visit.] ~~[Non-Network Benefits are not available.]~~		
Lab, X-ray or other preventive tests Note: In accordance with state law, for Network Benefits, no Copayment and/or Coinsurance or deductible applies to services for screening mammography testing or cervical cytological testing, except for services received in connection with a Physician's office visit. In this case, the Copayment and/or Coinsurance described above under Physician's Office Services - Sickness and Injury will apply.	***Network*** 100%	No	No
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] ~~[Non-Network Benefits~~	[Yes] [No] ~~[Non-Network Benefits are not available.]~~	[Yes] [No] ~~[Non-Network Benefits are not available.]~~

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Breast pumps	~~are not available.]~~ ***Network*** 100% ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100]] ~~[Non-Network Benefits are not available.]~~	No [Yes] [No] ~~[Non-Network Benefits are not available.]~~	No [Yes] [No] ~~[Non-Network Benefits are not available.]~~
[25.] [Prosthetic Devices]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices [that exceed $[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Benefits are limited to a single purchase of each type of prosthetic device every [[year] [[two-five] years]] [[12 - 60] months].] [Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.]	***[Designated Network]*** [[50 - 100]%] ***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]
[26.] Reconstructive			

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Procedures			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]			
	[Designated Network] [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*.] *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
	Network 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** 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*. *[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]*		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limited per year as follows: • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 - 100] visits for any combination of physical therapy, occupational therapy and speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.] [Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.] [Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]	***[~~Non-~~Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] ~~[Non-Network Benefits are not available.]~~	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] ~~[Non-Network Benefits are not available.]~~	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] ~~[Non-Network Benefits are not available.]~~
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% for the first [2 - 10] visits in a year; [50 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year] [Non-Network Benefits are not available.]	Benefits are not available.]	
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	Network [[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network***	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[50 - 100]%] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based center] [After you pay a Copayment of $[5 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per date of service at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
[Limited to [40 - 180] days per year.] [Limited to: • [[30 - 180] days per year in a Skilled Nursing Facility.] • [Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.] [Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[50 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
- 180] days per year.]	Expense] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay] [After you pay a	 [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[50 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
[30.] Substance Use Disorder Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for ~~Partial Hospitalization/Day Treatment and~~ services at a Residential Treatment ~~Facility~~facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.			
	[Designated Network] *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *[Outpatient]* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	- 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
	~~Non-~~Network *Inpatient* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - ~~5,000~~10,000] per Inpatient Stay] [After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] *Outpatient* [[50 - 100]%] [[50 - 100]% for Partial Hospitalization/Intensive	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied] [Yes] [No] [Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Outpatient Treatment] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.] [100% after you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.] [[50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	year.]		
	Non-Network		
	Inpatient	[Yes] [No]	[Yes] [No]
	[[50 - 100]%]		[Yes, after the Per Occurrence Deductible of $[100 - 2,000] per Inpatient Stay is satisfied]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		
	[100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay]		
	[100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	[After you pay a Copayment of $[100 - 2,000] per Inpatient Stay [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	Outpatient		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[50 - 100]% for Partial Hospitalization/Intensive Outpatient Treatment]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]		[Yes, after the Per Occurrence Deductible of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment is satisfied]
	[100% after you pay a Copayment of $[5 - 150] per individual visit; $[5 - 150] per group visit.]		
	[100% after you pay a Copayment of $[5 -		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment] [After you pay a Copayment of $[5 - 1,000] per session for Partial Hospitalization/Intensive Outpatient Treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [100% for visits for medication management]		
	[[50-100]% [after you pay a Copayment of $[5 - 150]] per visit for the first [2 - 10] visits in a year.]	[Yes] [No]	[Yes] [No]
	[[50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
[31.] Surgery - Outpatient			

[[1]Does not apply if prior authorization is required for all pain management.]

[Prior Authorization Requirement]

[For Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [[1]pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [$0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of $[10 - 1,000].] [You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
[Include when the enhanced benefits for certain procedures/clinical support is sold.] [When you received certain surgical procedures at a Designated Network Facility, your Benefit will be enhanced as described below:]	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [With clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 - 750].]] • [Without clinical support, the Copayment you pay for the facility charge for services provided at a Designated Facility will be reduced to $[0 - 750]. [The maximum reduction in Copayments is $[10 - 750].] [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] • [With clinical support, the Coinsurance you pay for the facility charge for services provided at a Designated Facility will be reduced to [0-50]%.[The Per Occurrence Deductible will [not apply][be reduced to $[100 - 750].]] • [Without clinical support, the Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Facility will be reduced to [0-50]%. [The Per Occurrence Deductible will [not apply][be reduced to $[100 -750].]] [You can determine the specific procedures for which enhanced	Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. You can receive clinical support services by calling *Clinical Support* at [the number shown on your ID card][1-800-XXX-XXXX].]			
	[[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Expense] [[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per date of service] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year] [After you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per date of service [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an ambulatory surgical center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per date of service at an ambulatory surgical center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date of service is satisfied]
	[[50 - 100]% at an outpatient Hospital-based surgical center] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per date

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center] [100% after you pay a Copayment of $[5 - 1,000] per date of service, to a maximum Copayment of $[5 - 5,000] per year at an outpatient Hospital-based surgical center] [After you pay a Copayment of $[5 - 1,000] per date of service at an outpatient Hospital-based surgical center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		of service is satisfied]
[32.] [Temporomandibular Joint Services]			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]			
	[Designated Network] [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*.]		
~~[Limited to $[1,000 - 20,000] per year.]~~	***[Network]*** [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*.]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Non-Network] [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*.] [Non-Network Benefits are not available.]		
[33.] Therapeutic Treatments - Outpatient			
[Prior Authorization Requirement] [For Non-Network Benefits you must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[Designated Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Deductible] we will pay [50 - 100]% of the remaining Eligible Expense] [[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center] [100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	remaining Eligible Expense] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 1,000] per treatment] [After you pay a Copayment of $[5 - 1,000] per treatment [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at a ~~free-standing~~freestanding center or in a Physician's office] [100% after you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office] [After you pay a Copayment of $[5 - 1,000] per treatment at a ~~free-standing~~freestanding center or in a Physician's office [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
	[[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No] [Yes, after the Per

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center] [After you pay a Copayment of $[5 - 1,000] per treatment at an outpatient Hospital-based center [and satisfy the Annual Deductible] we will pay [50 - 100]% of the remaining Eligible Expense]		Occurrence Deductible of $[5 - 1,000] per treatment is satisfied]
[34.] Transplantation Services			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [Non-Network Benefits will apply.] [For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.] [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	***Network*** 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.* ***Non-Network*** [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*.] [Non-Network Benefits are not available.]		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.] [In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • [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*.]]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance]
	[100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year]		
	[100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	[100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 150] per visit]	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance]
	[100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year]		
	[100% for the first [2 - 20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
	[100% after you pay a Copayment of $[5 - 150] per visit for the first [2 -		

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	20] visits in a year; [50 - 90]% for any subsequent visits in that year]		
[36.] [Virtual Visits]			
[Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	***[Network]*** [50 - 100%] [100% after you pay a Copayment of [$5 - 25] per visit] ***[Non-Network]*** [[50 - 100]%]	[Yes] [Yes] [No]	[Yes] [No] [Yes] [No]
[37.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] every [[12 - 36] months] [year] [2-3 years].]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	visit; [50 - 100]% for a Specialist Physician office visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% [after you pay a Copayment of $[5 - 75]] per visit for a Primary Physician office visit or $[5 - 150] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [[50 - 100]% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes [for a [Primary Physician][Specialist Physician] office visit]] [No [for a [Primary Physician][Specialist Physician] office visit]] [Non-Network Benefits are not available.]
[38.] [Wigs]			
[Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [12 - 36] months.]	***[Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]

Additional Benefits Required By District of Columbia Law

[39.] Child Health Screenings and Immunizations	
	[Designated Network] 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*. ~~***Network***~~ ~~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*.~~ ~~***Non-Network***~~ ~~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*.~~ ***Network*** 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*. ***Non-Network*** 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*.
[40.] Habilitative Services	

~~*Include when notification is required for any habilitative service.*~~

~~[1]*Include applicable Benefit level.*~~

~~**[Pre-service Notification Requirement]**~~

~~[For Non-Network Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [speech therapy] or as soon as is reasonably possible. If you fail to~~

*When Benefit limits apply, the limit refers to any combination of **[Designated Network Benefits,]** Network Benefits and Non-Network Benefits unless otherwise specifically stated.*			
Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
~~notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]~~			
Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. ~~•~~ [10-100] visits of speech therapy	***[Designated Network]*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit] ***Network*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
~~*Include when combined therapy visit limits apply.*~~ ~~[Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.]~~	~~***Non-Network***~~ ~~[50 - 100%]~~ ~~[100% after you pay a Copayment of $[5 - 150] per visit]~~	~~[Yes] [No]~~	~~[Yes] [No]~~
Include when combined therapy visit limits apply. [Any combination of outpatient habilitative services is limited to [10 - 160] visits per year.] *Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* [Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient habilitative services are limited to [10 - 160] visits per year.]	***Non-Network*** [50 - 100%] [100% after you pay a Copayment of $[5 - 150] per visit]	[Yes] [No]	[Yes] [No]

Eligible Expenses

[[1]Include if either Emergent ENRP or Non-Emergent ENRP applies or if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

[[2]Include if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

[[3]Include and delete #4 if non-emergent services by non-network physicians at a network facility are paid at less than billed charges (Non-Emergent ENRP applies) and if emergency health services are paid as member hold harmless (Emergent ENRP does not apply).]

[[4]Include and delete #3 if non-network physicians at a network facility and Emergency Health Services are paid at less than billed charges (Emergent and Non-Emergent ENRP applies).]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [[1]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. [[2]For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by us), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below.] [[3]For Covered Health Services provided by a non-Network facility based Physician (other than Emergency Health Services or services otherwise arranged by us), 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 as described below.] [[4]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.] For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For [Designated Network Benefits and] Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a [Designated Network and] Network provider, Eligible Expenses are our contracted fee(s) with that provider.

[[1]Do not include when Emergent ENRP applies.]

- When Covered Health Services are received from a non-Network provider [[1]as a result of an Emergency or] as arranged by us, Eligible Expenses are ~~billed charges unless a lower~~an amount ~~is negotiated or authorized by law~~negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[MNRP payment option.]

  - **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors~~, at our discretion~~.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for

the same or similar service within the geographic market, 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 an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com] for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
  - When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- For Mental Health Services and Substance Use Disorder 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.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.**]**

[Include if non-emergent services by non-network physicians at a network facility are not paid at billed charges (Non-Emergent ENRP).]

[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 [110-200]% 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, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance Use Disorder 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.**]**

[Include if Emergency Health Services by non-network physicians or facilities are paid at less than billed charges (Emergent ENRP).]

[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.
- [110-200]% 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, 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.**]**

[Traditional OON payment option.]

- **[**Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors~~, at our discretion~~.
- If rates have not been negotiated, then one of the following amounts:
  - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

- For Mental Health Services and Substance Use Disorder 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.
- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
- When a rate is not published by *CMS* for the service, we use 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.]

  IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.**]**

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility and/or a Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is

outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses~~ at our discretion~~.

In both cases, Network 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, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Document comparison by Workshare Compare on Tuesday, November 08, 2016 10:57:38 PM

Input:	
Document 1 ID	file://\\nas02082pn\data3\LGL\Esther Drew\Product-Mandate Filings\DC\2017 Filings\Large Group\UHCMA\Drafting\2016 Approved\SBN16-Medical-HMO-2011-Choice Plus-DC.doc
Description	SBN16-Medical-HMO-2011-Choice Plus-DC
Document 2 ID	file://\\nas02082pn\data3\LGL\Esther Drew\Product-Mandate Filings\DC\2017 Filings\Large Group\UHCMA\Drafting\SBN17-Medical-HMO-2011-Choice Plus-LG-DC.doc
Description	SBN17-Medical-HMO-2011-Choice Plus-LG-DC
Rendering set	Standard

Legend:	
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Style change	
Format change	
~~Moved deletion~~	
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Deleted cell	
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Padding cell	

Statistics:	
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Insertions	466
Deletions	156
Moved from	6
Moved to	6
Style change	0
Format changed	0
Total changes	634

UnitedHealthcare®
A UnitedHealth Group Company

November 9, 2016

Department of Insurance, Securities and Banking

Government of the Distrct of Columbia

801 First Street, N.E. Suite 701

Washington, D.C. 20002

Re: UnitedHealthcare Insurance Company

NAIC No. 79413

2017 Group Medical Product Filing - Large Group

Dear Sir/Madam:

On behalf of UnitedHealthcare Insurance Company, I am submitting the enclosed Group Medical Product forms for your Department's review and approval. Our intent is to use these forms for large employer groups only.

Most of these forms replace the forms previously filed & approved under SERFF Tracking Number UHLC-130012240, however the Catalyst Rider was approved under SERFF Tracking Number UHLC-128314914. The Performance Rewards Amendment is NEW.

The Gender Dysphoria Rider previously approved on July 18, 2016 under SERFF Tracking Number UHLC-130641011 will continue to be used with these forms.

Form Name	**Form Number**	**Flesch Score**	**N = New Form** **R = Replacement Form**
Certificate of Coverage	COC17.CER.I.11.LG.DC	50.6	R
Choice Schedule of Benefits	SBN17.CHC.I.11.LG.DC	55.8	R
Choice Plus Schedule of Benefits	SBN17.CHP.I.11.LG.DC	56.0	R
Options Schedule of Benefits	SBN17.OPT.I.11.LG.DC	54.5	R
Non-Differential Schedule of Benefits	SBN17.NDF.I.11.LG.DC	53.3	R
Outpatient Prescription Drug Rider (Network)	RDR.RX.NET.17.I.11.LG.DC	52.9	R

Form Name	Form Number	Flesch Score	N = New Form R = Replacement Form
Outpatient Prescription Drug Rider (Network/Non-Network)	RDR.RX.PLS.17.I.11.LG.DC	50.9	R
Outpatient Prescription Drug Schedule of Benefits (Network)	RDR.RXSBN.NET.17.I.11.LG.DC	57.5	R
Outpatient Prescription Drug Schedule of Benefits (Network/Non-Network)	RDR.RXSBN.PLS.17.I.11.LG.DC	59.2	R
Performance Rewards Amendment	POL.AMD.PR.I.11.DC	63.0	N
Catalyst Rider	CATL17.I.11.LG.DC	62.9	R

Explanation of Variable Text - and statement of variability

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 Enrolling Group. 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 Subscriber.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers regarding access and alternatives to electronic issuance.

Included in this filing are the Statements of Variability and Certification of Compliance/Readability.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Esther Drew

Digitally signed by Esther Drew
DN: cn=Esther Drew, o=UnitedHealthcare, ou=Regulatory Affairs, email=esther_l_drew@uhc.com, c=US
Date: 2016.11.09 22:32:56 -05'00'

Esther Drew

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