UnitedHealthcare of New Mexico, Inc.

Individual Exchange Medical Policy

303 Roma Ave, NW
Albuquerque, NM 87102
866-569-3491

Policy Number - [999-999-999]
Policyholder - [John Doe]
Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]
Premium Mode - [Monthly] [Quarterly]

UnitedHealthcare of New Mexico, Inc.

Individual Exchange Medical Policy

Agreement and Consideration

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

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy, except that your coverage may end for events as described in *Section 4: When Coverage Ends*, under *Events Ending Your Coverage* and *Other Events Ending Your Coverage*.

This Policy will renew on January 1 of each calendar year. On January 1st, we may make modifications in coverage if such modifications are made on a uniform basis for all individuals with the same product. In addition, we may make modifications at any time if the modification is directly related to a State or Federal requirement and the modification is made within a reasonable time period after the State or Federal requirement is imposed or modified.

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

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

Nothing in this section requires us to renew or continue coverage for which your continued eligibility would otherwise be prohibited under applicable law.

10-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

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

UnitedHealthcare of New Mexico, Inc.

Jed Armstrong, President and CEO

What Is the Policy?

This Policy is a legal document between UnitedHealthcare of New Mexico, Inc. and you and describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's *Application* and payment of the required Premium.

This Policy includes:

- *Summary of Benefits and Coverage ("SBC")*.
- The Policyholder's *Application*.
- Riders.
- Amendments.

This Policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Can This Policy Change?

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

Other Information You Should Have

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

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

We are delivering this Policy in New Mexico. This Policy is governed by New Mexico law.

Member Rights

All Members have these rights:

- The right to available and accessible services when Medically Necessary, as determined by the primary care or treating physician in consultation with the UnitedHealthcare, 24 hours per day, seven days per week for urgent or Emergency Health Care Services, and for other Health Care Services as defined by the contract or the Policy.
- The right to be treated with courtesy and consideration, and with respect for your dignity and need for privacy.
- The right to be provided with information concerning UnitedHealthcare's policies and procedures regarding products, services, Physicians, appeals procedures and other information about the Benefits provided.
- The right to choose a Primary Care Physician within the limits of the covered Benefits, plan network, including the right to refuse care of specific health care professionals.
- The right to receive from your Physician, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of UnitedHealthcare's position on treatment options; if you are not capable of understanding the information, the explanation shall be provided your next of kin, guardian, agent or surrogate, if available, and documented in your medical record.
- The right to all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language that you understand.

- The right to prompt notification, as required in this rule, of termination or changes in Benefits, Covered Health Care Services or Network Providers.
- The right to file a complaint or appeal with UnitedHealthcare or *The New Mexico Office of Superintendent of Insurance* and to receive an answer to those complaints in accordance with existing law.
- The right to privacy of medical and financial records maintained by UnitedHealthcare and its health care providers, in accordance with existing law.
- The right to request any financial arrangements or provisions between UnitedHealthcare and its Network providers which may restrict referral or treatment options or limit the services offered to a Covered Person.
- The right to adequate access to qualified health professionals for the treatment of Covered Health Care Services near where you live or work within the UnitedHealthcare service area in New Mexico.
- The right to affordable health care, with limits on Out-of-Pocket expenses, including the right to seek care from an Out-of-Network Provider, and an explanation of your financial responsibility when services are provided by an Out-of-Network Provider, or provided without required prior authorization.
- The right to an approved example of the financial responsibility incurred by a Covered Person when going out-of-network.
- The right to detailed information about coverage, maximum Benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription Benefits, and all requirements that you must follow for prior authorization and utilization review.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to the health care insurer's internal review, the right to a secondary appeal, and the right to request the *New Mexico Superintendent's* assistance.

Introduction to Your Policy

This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*.

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

How Do You Use This Document?

Read your entire *Policy* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Policy* and *Summary of Benefits and Coverage ("SBC")* and any attachments in a safe place for your future reference. You can also get this Policy at www.myuhc.com/exchange.

Review the Benefit limitations of this *Policy* by reading the *SBC* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 7: General Legal Provisions* to understand how this Policy and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

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

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

How Do You Contact Us?

Call the telephone number listed on your ID card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Premiums

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

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

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

This Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Summary of Benefits and Coverage ("SBC")* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

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

How Do You Access Benefits?

The service area is the state of New Mexico. The member must live in the state of New Mexico in order to enroll in this HMO plan. You must see a New Mexico Choice Network Physician in order to obtain Benefits. The Network Area may include select Network providers located in a neighboring state.

This Benefit plan does not provide an out-of-Network level of Benefits. Benefits are not available for services provided by Out-of-Network Providers except as follows:

- For Emergency Health Care Services.
- For Covered Health Care Services received at a Network facility on a non-Emergency basis from Out-of-Network Physicians unless you knowingly choose to receive services from an Out-of-Network Physician.
- For Medically Necessary Covered Health Services that are not available from a Network provider.
- For continuity of care Benefits during a brief transition period. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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

If you receive Emergency care out-of-Network, including Air Ambulance service:

- You are only responsible for paying your Co-payment, deductible, or Co-insurance percentage as you would for the same care from a Network provider or facility.
- You do NOT need to get prior authorization for Emergency services.
- Your care can continue until your condition has stabilized. If you require additional care after stabilization, call us at the telephone number on the back of your ID card and we will help you receive that care from a Network provider.
- You cannot be balance billed.

"Balance billing" means an Out-of-Network Provider's practice of issuing a bill to a Covered Person for the difference between the Out-of-Network Provider's billed charges on a claim and any amount paid by the health insurance carrier as reimbursement for that claim, excluding any cost sharing amount due from the Covered Person.

If you receive care from an Out-of-Network Provider at a Network facility, such as a Hospital that is in your plan, you are only responsible for paying your Co-payment, deductible, or Co-insurance percentage as you would for the same care from a Network provider or facility if:

- You did not consent to services from an Out-of-Network Provider,
- You were not offered the service from a Network provider, or
- The service was not available from a Network provider – as determined by your health care provider and us.

If you get a bill from an Out-of-Network Provider under any of the above circumstances that you do not believe is owed:

- Call us first at the telephone number listed on the back of your ID card. We will try to the resolve the issue with the provider on your behalf.
- Contact the *New Mexico Office of Superintendent of Insurance* if the problem has not been resolved by us –https://www.osi.state.nm.us/pages/misc/mhcb-complaint or 1-855-427-5674.

To help stop improper out-of-Network bills, we will:

- Notify you if your provider leaves our Network and allow you transitional care with that provider at the Network Benefit level for up to 90 days depending on your condition and course of treatment.
- Verify the accuracy of our provider directory information at least every 90 days.
- Confirm whether a provider is a Network provider if you contact us at the telephone number on the back of your ID card or online at https://www.uhc.com/xnmdocfindoa2024. If our representative provides inaccurate information that you rely on in choosing a provider, you will only be responsible for paying your Network cost sharing amount for care received from that provider.

You have the right to receive notice of the following before you receive out-of-Network care at a Network facility:

- A good faith estimate of the charges for out-of-Network care.
- At least five days to change your mind before you receive a scheduled out-of-Network service. If you choose to receive out-of-Network care you will be responsible for out-of-Network charges that we do not cover.
- A list of Network providers and the option to be referred to any such provider who can provide necessary care.

If you pay an Out-of-Network Provider more than we determine you owe:

- The provider will owe you a refund within 45 days of receipt of payment by us.
- If you do not receive a refund within that 45-day period, the provider will owe you the refund plus interest.
- You may contact the *New Mexico Office of Superintendent* of Insurance at https://www.osi.state.nm.us/pages/misc/mhcb-complaint and 1-855-427-5674 for assistance or to appeal the provider's failure to provide a refund. You need to file the appeal within 180 days of the 45-day refund period expiration.

We shall reimburse a surprise medical bill as required by law regardless of the situs of delivery of the medical care, including medical care rendered out-of-state.

"Surprise medical bill" means a bill that an Out-of-Network Provider issues to a Covered Person for health care services rendered in the following circumstances, in an amount that exceeds the Covered Person's cost sharing obligation that would apply for the same health care services if these services had been provided by a Network provider:

- Emergency care provided by the Out-of-Network Provider; or
- Health care services, that are not emergency care, rendered by an Out-of-Network Provider at a Network facility where:
  - A Network provider is unavailable;

- An Out-of-Network Provider renders unforeseen services; or
- An Out-of-Network Provider renders services for which the Covered Person has not given specific consent for that Out-of-Network Provider to render the particular services rendered.

Surprise billing does not include health care services received by a Covered Person when a Network provider was available to render the health care services and the Covered Person knowingly elected to obtain the services from an Out-of-Network Provider without prior authorization.

Emergency Health Care Services provided by an Out-of-Network Provider will be reimbursed as set forth under *Allowed Amounts* as described in *Section 5: How to File a Claim.*

Covered Health Care Services provided at certain Network facilities by an Out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts as described in *Section 5: How to File a Claim.* For these Covered Health Care Services, "certain Network facility" is limited to a Hospital, a Hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified by the *Secretary.*

Ground and Air Ambulance transport provided by an Out-of-Network Provider will be reimbursed as set forth under *Allowed Amounts* as described in *Section 5: How to File a Claim.*

Except for services for the scenarios laid out at the beginning of this section *How Do You Access Benefits?*, Network coverage will not be provided if an Out-of-Network Provider is utilized.

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.

Reporting Inaccurate Provider Information

When searching for a provider online at https://www.uhc.com/xnmdocfindoa2024, you can report possible inaccurate, incomplete or misleading information (including demographic information such as address, phone, etc.) by using the “Report Incorrect Information” link found in the bottom right corner under the provider’s detailed information. In addition, you can report potential inaccurate information found in the online or paper directories by emailing us at provider_directory_invalid_issues@uhc.com or by calling the number on the back of your ID card. Reporting issues will result in an outreach to the provider’s office to verify all directory demographic data.

Behavioral health provider information issues can also be reported by calling 1-800-557-5745, or by emailing provider_feedback@optum.com.

Choose Your Physician

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

Obtain Prior Authorization

Certain types of care require prior authorization by us. This means that you or your provider must ask us to approve the care before you receive it.

A complete and current list of the Covered Health Care Services that are subject to a prior authorization requirement can be found at uhc.com/NMpriorauth. Prescription Drug Products that are subject to a prior authorization requirement can be located on your 2024 New Mexico Prescription Drug List at https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists/individual-exchange.The Uniform prior authorization form can be found online at https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/pa-requirements/commercial/NM-Commercial-Prior-Author-Form.pdf.

We may decline payment for unauthorized care. If your provider is a Network provider, and you did not agree to receive unauthorized care, your provider cannot bill you for the care. If you received unauthorized care from a provider who is not a Network provider you may be fully responsible for the resulting bills.

We do not require prior authorization for:

- Emergency services;
- Contraception services that are not subject to any cost sharing; or
- An obstetrical or gynecological ultrasound.

However, we require authorization for continued inpatient care if you are admitted to a Hospital for Emergency treatment, but your condition is stabilized. You or your provider must notify us within 24 hours, or as soon as reasonably possible, from when you begin receiving Emergency inpatient treatment, and within 24 hours after the Emergency ends and your condition stabilizes.

"Stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, as determined by the emergency physician or treating provider.

The following services require prior authorization:

- Ambulance services (non-emergency air/ground).
- Cellular and gene therapy (all services).
- Clinical trials (all services).
- Congenital heart disease (surgery).
- Dental services, Hospital and General Anesthesia (all services).
- Diabetes services (insulin pumps). Unless there is a change in diagnosis or in a Covered Person's management or treatment of diabetes or its complications, we will not require more than one prior authorization per Policy period for any single drug or category of item if prescribed as Medically Necessary by the Covered Person's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a Covered Person has received prior authorization during the Policy year will not be subject to additional prior authorization requirements in the same Policy year if prescribed as Medically Necessary by the Covered Person's health care practitioner.
- DME, orthotics and supplies. (Certain DME requires prior authorization. Please contact the member call center or your UnitedHealthcare representative for more information.) Unless there is a change in diagnosis or in a Covered Person's management or treatment of diabetes or its complications, we will not require more than one prior authorization per Policy period for any single drug or category of item if prescribed as Medically Necessary by the Covered Person's health care practitioner. Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a Covered Person has received prior authorization during the Policy year will not be subject to additional prior authorization requirements in the same Policy year if prescribed as Medically Necessary by the Covered Person's health care practitioner.
- Home health care (all services).
- Hospice (all services).
- Hospital inpatient (all admits).
- Lab, x-ray and diagnostics (genetic testing, sleep studies and transthoracic echocardiogram).
- Major diagnostic and imaging (CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology).
- Mental health care and substance-related and addictive disorders services:
    - Inpatient (inpatient admissions including residential treatment facilities) except if the admission is an initial inpatient substance use treatment service;
    - Subsequent (non-initial) in-network outpatient substance use treatment services;

- Outpatient (partial hospitalization/day treatment; intensive outpatient treatment programs; Outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy including Applied Behavioral Analysis (ABA)).

The exception to the above is for in-network acute or immediately necessary care and in-network acute episodes of chronic mental health or substance use disorder conditions. In-network acute or immediately necessary care, in-network acute episodes of chronic mental health or substance use disorder conditions and initial in-network inpatient or outpatient substance use treatment services are subject to notification requirements by the network provider after the initiation of such services. If the network provider fails to provide notification, such services shall be subject to prior authorization.

- Pregnancy – maternity services (if exceeds mandated length of stay).
- Prosthetic devices (all services).
- Reconstructive procedures (all services).
- Skilled nursing facility/inpatient rehabilitation (all services).
- Surgery – outpatient (cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery).
- Temporomandibular Joint (TMJ) Services and Craniomandibular Disorder Services (inpatient).
- Therapeutics – outpatient (intensity modulated radiation therapy and radiation oncology).
- Transplantation services (all services).

Contact us by calling the number on your ID card for additional information.

Prior Authorization Process

Your Network provider is responsible for knowing what care requires prior authorization, and for submitting a prior authorization request to us.

We will give any provider access to all necessary forms and instructions for making the request.

An Out-of-Network Provider is not required to submit a prior authorization request for you. If you visit one of these providers, and that provider will not submit a prior authorization request, you may submit a prior authorization request on your own behalf, or on behalf of a dependent. We will help you obtain required documents and show you the guidelines that apply to the request. Because your provider should be able to gather required information and submit it sooner, we encourage you to have your provider request prior authorization whenever possible.

Prior Authorization Review Timelines

If we do not deny a complete prior authorization request within these time frames the request is automatically approved:

- Urgent Care or Prescription Drugs – if you require urgent medical care, behavioral health care or a prescription drug, we will resolve the request within 24 hours.
- Non-Urgent Medicine – if you do not have an urgent need for a prescription drug, we will resolve the request within three business days if your provider:
  - Uses the prior authorization request form approved by the *New Mexico Office of Superintendent of Insurance;*
  - Requests an exception from an established step therapy process; or
  - Requests to prescribe a drug that we do not usually cover.
- Other Requests – We will resolve all other requests within seven (7) business days.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our utilization management staff can answer questions your provider might have concerning required information or any aspect of the request submission process. If we require additional information to evaluate a request, we will request it from your provider. Your provider will have at least 4 hours to provide requested information in connection with an urgent prior authorization request, and at least two calendar days for any other type of request.

Why We Review

Our review of a prior authorization request will determine if the proposed care involves a Covered Health Care Service, is Medically Necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning medical necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional.

Prior authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review

If you received care without a required prior authorization, we allow your provider to request authorization retrospectively. Our utilization management team will assist your provider in the submission of a retrospective authorization request. However, we do not routinely authorize care retrospectively. Retrospective authorization decisions will be made within 30 days after receiving all required information.

Behavioral Health Care

Requests for behavioral health care and prescriptions are subject to the same prior authorization processes and timelines as requests for medical care and Prescription Drug Products. We will not retroactively change a prior authorization for behavioral health services after they have been rendered, except in cases of fraud. We will not require prior authorization for acute behavioral health care, acute episodes of chronic behavioral health conditions, or initial substance use treatment. We will not stop coverage without consulting with the treating behavioral health provider. No prior authorization or step therapy for Medically Necessary substance use treatment medications will be required.

Authorization Denial

We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process can be found in *Section 6: Summary of Health Insurance Grievance Procedure*. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

Covered Health Care Services which Require Prior Authorization

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

Network facilities and Network providers cannot bill you for services they do not prior authorize as required, unless you knowingly choose to receive services that the Network facilities and Network providers did not approve or seek authorization for.

What Will You Pay for Covered Health Care Services?

An Annual Deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Annual Deductibles are calculated on a calendar or Policy year basis. You might have an individual Annual Deductible or a family Annual Deductible. Your *Summary of Benefits and Coverage (SBC)* will tell you if you have an Annual Deductible and if so, how much it is. If you have a family Annual Deductible, then your individual Annual Deductible amount counts toward fulfillment of your family Annual Deductible.

If you have an Annual Deductible, you must meet it, or fulfill it, before we begin to make payment on claims for Covered Health Care Services that are subject to the Annual Deductible. For example, if you have a $250 Annual Deductible, you must pay $250 in claims before we make any payment on claims for services subject to the Annual Deductible. We apply that $250 toward your Annual Deductible and it is met, or fulfilled.

The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined are described in *Section 5: How to File a Claim.*

The Out-of-Pocket Limit is the maximum you pay per year for the Annual Deductible, Co-payments and Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of the Allowed Amounts during the rest of that year. Out-of-Pocket Limits are calculated on a calendar or Policy year basis.

You might have an individual Out-of-Pocket Limit or a family Out-of-Pocket Limit. Your *Summary of Benefits and Coverage (SBC)* will tell you if you have an Out-of-Pocket Limit and if so, how much it is. If you have a family Out-of-Pocket Limit, then your individual Out-of-Pocket Limit amount counts toward fulfillment of your family Out-of-Pocket Limit. Your Out-of-Pocket Limit is considered to be reached once your Annual Deductible (if any), Co-payments and Co-insurance add up to the amount of your Out-of-Pocket Limit. For example, if you have a $1,000 Out-of-Pocket Limit, you must pay $1,000 of the Allowed Amounts for claims out of your own pocket towards the cost of Covered Health Care Services. Then we cover 100% of the Allowed Amounts for claims for Covered Health Care Services for the rest of the year.

The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:

- Monthly premiums.
- Any charges for non-Covered Health Care Services.
- Charges that exceed Allowed Amounts, when applicable.

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

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Summary of Benefits and Coverage ("SBC").*

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, Benefits for that particular condition or disability are subject to your previous carrier's obligation under state law or contract, and we will coordinate payment of Benefits with the prior carrier, as applicable. Refer to *Section 9: Coordination of Benefits* for information on how Benefits under the Policy will be coordinated with those of another Plan, as defined in that section.

Our Responsibilities

Determine Benefits

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

We will determine the following:

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

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

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described under *Section 6: Summary of Health Insurance Grievance Procedures*. You may also call the telephone number on your ID card.

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

billed, unless surprise billing laws apply. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by calling the telephone number on your ID card.

Unless surprise billing laws apply, we may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com/exchange for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

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

Establish and Maintain a Consumer Advisory Board

We have a *Consumer Advisory Board* that meets on a quarterly basis to review our general operations from the consumer's perspective and offer recommendations. Current enrollees are welcome to join. Members of the *Consumer Advisory Board* may not be *UnitedHealthcare* employees nor immediate family of *UnitedHealthcare* employees. For more information about the *Consumer Advisory Board*, or to inquire about becoming a member, please call the toll-free number on the back of your insurance ID card.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary, described as a Covered Health Care Service and covered benefit in this Policy under *Section 1: Covered Health Care Services* and not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations.* Preventive services, as described under *Preventive Care Services*, are also covered. (See definitions of Medically Necessary and Covered Health Care Service in *Section 8: Defined Terms*.) See the section entitled *Your Right to Request an Exception When a Medication is Not Listed on the Prescription Drug List (PDL)* under *Section 6* for the exception process allowing for coverage of clinically appropriate prescription drugs not otherwise covered under the Policy.
- You receive Covered Health Care Services while this Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements.

Covered Health Care Service Benefits will not be denied when otherwise provided for the treatment of such Injury if the Injury results from an act of domestic violence or a medical condition including both physical and mental health conditions.

A Covered Person cannot be discriminated against in eligibility for coverage or Benefits based on their sex, sex assigned at birth, sexual orientation, sex stereotyping, gender, gender identity, recorded gender, race, religion, or national origin.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Summary of Benefits and Coverage ("SBC")* for details about:

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

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

Acupuncture Services

- Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by the practitioner/provider.
- It is recommended that Acupuncture be part of a coordinated plan of care approved by your practitioner/provider.
- Benefits include acupressure treatment.

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.
- Doctor of Oriental Medicine.

Acupuncture is limited to 20 visits per policy period unless for rehabilitative or habilitative purposes.

Ambulance Services

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

The following types of ambulance services are covered: Emergency Ambulance Services, High-Risk Ambulance Services and Inter-facility Transfer Services.

Emergency Ambulance Services are ground or air ambulance services delivered to a Covered Person who requires Emergency Health Care Services under circumstances that would lead a reasonable/prudent layperson acting in good faith to believe that transportation in any other vehicle would endanger your health. Emergency ambulance services are covered only under the following circumstances:

- Within New Mexico, to the nearest Network facility where Emergency Health Care Services can be rendered, or to an out-of-Network facility if a Network facility is nor reasonably accessible or able to provide the required care. Such services must be provided by a licensed ambulance service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Outside of New Mexico, to the nearest appropriate facility where Emergency Health Care Services can be rendered. Such services must be provided by a licensed ambulance service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Ground or air ambulance services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.
- In determining whether a Covered Person acted in good faith as a reasonable/prudent layperson when obtaining emergency ambulance services, the following will be taken into consideration:
    - Whether the Covered Person required Emergency Health Care Services.
    - The presenting symptoms.
    - Whether a reasonable/prudent layperson who has average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health.
    - Whether the Covered Person was advised to see ambulance service by a practitioner/provider or by our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless limited or excluded under this Policy.

High-risk ambulance services are ambulance services that are non-emergency, Medically Necessary for transporting a high-risk patient, and prescribed by your practitioner/provider. Benefits for high-risk ambulance services are limited to:

- Air Ambulance service when Medically Necessary.
- Neonatal ambulance services, including ground or Air Ambulance, when necessary to protect the life of the infant or mother, for medically high-risk pregnant women with an impending delivery of a potentially viable infant to the nearest available Tertiary Care Facility for newly born infants.
- Ground or Air Ambulance services to any Level I or II or other appropriately designated trauma/burn center according to treatment protocols.

Inter-facility Transfer Services are defined as ground or Air Ambulance service between Hospitals, skilled nursing facilities or diagnostic facilities. Inter-facility Transfer Services are covered only if they are:

- Medically Necessary.
- Prescribed by your practitioner/provider.

- Provided by a licensed ambulance service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.

Ambulance service (ground or air) to the coroner's office or to a mortuary is not covered unless the ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such a pronouncement.

Allowed Amounts for ground and Air Ambulance transport provided by an Out-of-Network Provider will be determined as described below under *Allowed Amounts* in *Section 5: How to File a Claim.*

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

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

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

  - "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.

Anesthesia

Benefits include coverage for anesthesia and the administration of anesthesia. General anesthesia may be provided where local anesthesia is ineffective because of acute infection, anatomic variation or allergy. Depending on where a service is received, Benefits will be provided under the corresponding Benefit category in this Policy.

Hypnotherapy is covered when performed by an anesthesiologist, trained in the use of hypnosis, when Medically Necessary or when:

- Used within two weeks prior to surgery for chronic pain management, and
- For chronic pain management when part of a coordinated treatment plan.

Chiropractic Services

Chiropractic services are available for specific medical conditions and are not available for maintenance therapy such as routine adjustments. Chiropractic services are subject to the following:

- The practitioner/provider determines in advance that chiropractic treatment can be expected to result in significant improvement in your condition.
- Chiropractic care as defined in the *Chiropractic Physicians Practice Act* including, but not limited to, the correction of misalignments or subluxations of the articulations and adjacent structures, more especially those of the vertebral column and pelvis, for the purposes of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustments and manipulation of the human structure. The *Chiropractic Physicians Practice Act* defines the scope of services allowed to be performed by a licensed doctor of chiropractic. It grants chiropractors the right to practice chiropractic as taught and practiced in standard colleges of chiropractic. Such practice includes being able to diagnose, palpate and treat injuries and other conditions relating to the basic concepts of chiropractic.
- Subluxation must be documented by examination and documented in the patient's record.

Biofeedback is only covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.

Chiropractic Services are limited to 20 visits per policy period unless for rehabilitative or habilitative purposes. Your Co-payment or Co-insurance for chiropractic services will not be greater that what your cost share would be for primary care services.

Clinical Trials

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

- Cancer, the prevention of recurrence of cancer, the early detection or treatment of cancer for which no equally or more effective standard cancer treatment exists.
- Other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Medical services or treatment that is a benefit under this plan that would be covered if the patient were receiving standard cancer treatment or other treatment for a life-threatening medical condition.
- The available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-Investigational alternative.
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

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

The personnel providing the clinical trial or conducting the study:

- Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise;
- Agree to accept reimbursement as payment in full from the health plan at the rates that are established by that plan and are not more than the level of reimbursement applicable to other similar services provided by health care providers within the plan's provider network; and
- Agree to provide written notification to the health plan when a patient enters or leaves a clinical trial.

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

- The provider referring you to the clinical trial is a Network provider who has concluded that your participation in the clinical trial would be appropriate based on the fact that you are eligible to participate in the clinical trial in accordance with the trial protocol, or
- You have provided credible medical and scientific information that establishes that your participation in the clinical trial would be appropriate based on the fact that you are eligible to participate in the clinical trial in accordance with the trial protocol.

Coverage for routine patient care costs means a:

- Covered Health Care Service or treatment that is a Benefit under this plan that would be covered if the patient were receiving standard cancer treatment or other treatment for a life threatening medical condition, or
- For clinical trials for cancer or other life threatening medical condition, a drug provided during the clinical trial if the drug has been approved by the *U.S. Food and Drug Administration (FDA),* even if the drug has

not been approved by the *FDA* for the treatment of the particular condition, as long as the drug is not paid for by the manufacturer, distributor or provider of the drug.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.
- The patient encounters other life-threatening diseases or conditions during the course of treatment.
- A reasonable expectation shown in clinical or pre-clinical data that the clinical trial will be at least efficacious as any non-investigational alternative.
- The clinical trial is being provided in New Mexico as part of a scientific study of a new therapy or intervention and is for the prevention, prevention of reoccurrence, early detection, treatment or palliation of cancer, or other life-threatening medical treatment for which no equally or more effective standard treatment exists, in humans and in which the scientific study includes all of the following:
  - Specific goals.
  - There is no non-investigational treatment equivalent to the clinical trial.
  - A rationale and background for the study.
  - Criteria for patient selection.
  - Specific direction for administering the therapy or intervention and for monitoring patients.
  - A definition of quantitative measures for determining treatment response.
  - Methods for documenting and treating adverse reactions.
  - A reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

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. *Category B* devices (Non-Experimental, but still Investigational) means a device type in which the underlying questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained *U.S. Food and Drug Administration (FDA)* approval for the device type. These devices are under investigation to establish substantial equivalence to a predicate device, that is, to establish substantial equivalence to a previously/currently legally marketed 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 meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.
- Costs of the clinical trial that are customarily paid for by the government, biochemical, pharmaceutical or medical device industry sources.
- The cost of a non-FDA approved investigational drug, device, or procedure.

- Clinical trials designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent.
- Costs associated with managing the research that is associated with the clinical trial.
- Costs that would not be covered if non-Investigational treatments were provided.
- Costs of tests that are necessary for the research of the clinical trial.
- Costs paid for or not charged by the clinical trial providers.
- The cost of a non-health care service the patient is required to receive as a result of participation in the clinical 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. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- For clinical trials for cancer and other life-threatening diseases only:
  - *U.S. Food and Drug Administration (FDA)* when related to an investigational new drug application.
  - A qualified research entity that meets the criteria established by the *National Institutes of Health (NIH)* for grant eligibility.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you 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 Care Service and is not otherwise excluded under the Policy.

The personnel providing the clinical trial or conducting the study:

- Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise;
- Agree to accept reimbursement as payment in full from the health plan at the rates that are established by that plan and are not more than the level of reimbursement applicable to other similar services provided by health care providers within the plan's provider network; and
- Agree to provide written notification to the health plan when a patient enters or leaves a clinical trial.

Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this Policy.

COVID-19 Testing and Treatment

Requirements under this section include COVID-19 diagnostic testing, screening, vaccines, and treatment for Covered Persons as determined by the Covered Person's health care provider. Prior authorization is not required. Covered services include:

- No cost sharing requirement for the provision of testing, vaccines, and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or for any disease or condition which is the cause of, or subject of, a public health emergency. A public health emergency exists when declared by the state of New Mexico or federal government.

Dental Anesthesia

Benefits include hospitalization and general anesthesia for dental surgery provided in a Hospital or an Alternate Facility for:

- A Covered Person who exhibits physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
- A Covered Person for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
- An Enrolled Dependent child or adolescent who is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
- A Covered Person with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
- Other procedures for which hospitalization or general anesthesia in a Hospital or Alternate Facility is Medically Necessary.

Dental Services

Benefits include Medically Necessary services as follows:

- Accidental Injury to sound, natural teeth, jawbones or surrounding tissue. Dental injury caused by chewing, biting or malocclusion is not considered an accidental Injury and will not be covered.
- Temporomandibular and craniomandibular joint disorders as described under *Temporomandibular Joint (TMJ) Services and Craniomandibular Disorder Services* in *Section 1: Covered Health Care Services*.
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.

- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Hospitalization, day surgery, outpatient and/or anesthesia for covered and non-covered dental services are covered if provided in a Hospital or ambulatory surgical center for dental surgery:
    - For Covered Persons who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
    - For Covered Persons for whom local anesthesia is ineffective of acute infection, anatomic variations or allergy.
    - For covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
    - For Covered Persons with extensive oral-facial or dental trauma for which treatment under local anesthesia would be inefficient or compromised.
    - For other procedures for which hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery that is Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Pediatric dental services, including routine check-ups, major dental care, and orthodontia. See *Section 11: Pediatric Dental Care Services*.
- Removal of infected teeth in preparation for an organ transplant, joint replacement surgery or radiation therapy of the head and neck.

Diabetes Services

Your health benefits plan contract provides coverage for basic health services for individuals with Type 1 diabetes (insulin dependent diabetes), Type 2 diabetes (non-insulin dependent diabetes), and gestational diabetes (individuals with elevated blood glucose levels induced by pregnancy). These basic health services consist of:

- Preventive care.
- Emergency care.
- Inpatient and outpatient hospital and Physician care.
- Diagnostic laboratory services.
- Diagnostic and therapeutic radiological services.
- Prescription medications.
- Treatment and supplies.

Benefits will be provided under the corresponding Benefit category in this Policy. Benefits for medications and diabetic testing supplies normally available by prescription order or refill are provided under the *Outpatient Prescription Drugs* section.

This coverage is a basic health care service that entitles you to the medically accepted standard of medical care for diabetes, when Medically Necessary, and will not be reduced or eliminated.

Generally, your Provider will diagnose you with diabetes and prescribe Medically Necessary Durable Medical Equipment (DME), diabetic testing supplies, insulin, or other prescription medications used for the treatment of diabetes. Generally, once a Provider diagnoses you with diabetes, any Provider can then prescribe Medically Necessary Durable Medical Equipment (DME), diabetic testing supplies, insulin, or other prescription medications.

This section explains covered Benefits and services. Nothing in this section of your plan contract shall be construed to require payment for diabetes resources that are not covered Benefits or services.

Basic Health Care Services

Your health Benefits plan covers the following Benefits for diabetes self-management training provided by a certified, registered or licensed health care professional with recent education in diabetes management:

- Medically Necessary visits upon the diagnosis of diabetes;
- Visits following a diagnosis indicating a significant change in your symptoms or condition that warrants changes in your self-management;
- Visits when re-education or refresher training is prescribed by your Provider with prescribing authority;
- Telephonic visits with a Certified Diabetes Educator (CDE). Approved diabetes educators may be required to be practitioners/Providers who are registered, certified or licensed health care professional with recent education in diabetes management; and
- Medical nutrition therapy related to diabetes management.

Prescription Medications, DME, Insulin and Supplies

Your plan contract covers DME, diabetic testing supplies, insulin or other prescription medications needed to monitor and control your diabetes as follows:

- Insulin pumps when Medically Necessary, prescribed by a Provider;
- Blood glucose monitors, including those for individuals with disabilities;
- Specialized monitors/meters for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading urine and ketone strips;
- Lancets and lancet devices;
- Insulin;
- Injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;
- Syringes;
- Oral diabetic prescription medications for controlling blood sugar levels;
- Glucagon emergency kits; and
- Medically Necessary podiatric DME for prevention of feet complications associated with diabetes as follows:
  - Therapeutic molded or depth-inlay shoes;
  - Functional orthotics;
  - Custom molded inserts;
  - Replacement inserts;
  - Preventive devices; and
  - Shoe modifications for prevention and treatment.

Your health Benefits plan requires the use of approved DME brands that are purchased at in-Network pharmacy, preferred vendor or preferred Durable Medical Equipment supplier.

This health Benefits plan will also cover items not specifically listed as covered when new and improved DME and prescription medications for the treatment and management of diabetes are approved by the *U.S. Food and Drug Administration*. When such items are approved, we will update our Prescription Drug List and other information to

provide adequate access to these resources. Coverage of newly approved prescription medications for the treatment and management may be subject to prior authorization and step therapy requirements.

Prior Authorization

Medically Necessary DME, diabetic testing supplies, insulin or other prescription medications used for the treatment of diabetes and covered under your health Benefits plan can be subject to prior authorization and step therapy requirements. We will not require your Provider to submit more than one prior authorization request per Policy year for any single medication or category of covered item, unless there is a change in your diagnosis, management or treatment of diabetes or its complications. The one prior authorization per year limitation applies to changes in the following:

- Prescribed dose of a medication;
- Quantities of supplies needed to administer a prescribed medication;
- Quantities of blood glucose self-testing equipment and supplies; or
- Quantities of supplies needed to use or operate devices for which an enrollee has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same Policy year if deemed Medically Necessary by the enrollee's health care practitioner.

Cost Sharing

- The amount you will pay for a preferred Prescription Drug List prescription insulin, or a Medically Necessary alternative will not exceed a total of twenty-five dollars ($25.00) per thirty-day supply.
- Coverage of all other diabetes related Benefits, treatment and supplies may be subject to cost sharing (deductible, Co-payment and Co-insurance) consistent with the cost sharing imposed to other Benefits under the same contract. This cost sharing will not exceed the cost sharing established for similar benefits under your health Benefits plan.

Network Access

We maintain an adequate network of Providers, pharmacies, Durable Medical Equipment suppliers and other suppliers to provide you with adequate and timely access to Medically Necessary diabetes resources. If a contract lapses or is terminated, we will ensure the availability and continuity of your care through another Network Provider or a single-case agreement with an out-of-Network Provider.

Reimbursement

We guarantee coverage for the Medically Necessary DME, diabetic testing supplies, insulin or other prescription medications, in this section and in the *Outpatient Prescription Drugs* section within the limits of your health Benefits plan. We will reimburse you if the before mentioned Benefits were not accessible in a timely manner and you incurred out of pocket expenses.

If you are unable to access Medically Necessary DME, diabetic testing supplies, insulin or other prescription medications covered under this health Benefits plan in a timely manner, and when needed, you can:

- Contact us at the telephone number on your ID card and we will assist you with finding an in-Network Provider or refer you to an out-of-Network Provider that can deliver the Benefit or service in a timely manner; or
- Pay out of pocket and file a claim with us as described in *Section 5: How to File a Claim*. We will reimburse you the amount of the covered Benefit on the same basis as if the Benefit was obtained in-Network. Once we receive your written request and receipt for out-of-pocket expenses, we will reimburse you within 30 (thirty) days. If we fail to reimburse you in a timely manner, we will pay an interest rate of 18 % (eighteen percent) per year on the amount due.

If you are not satisfied with our resolution you can file a complaint with the Office of the Superintendent of Insurance at https://www.osi.state.nm.us/pages/misc/mhcb-complaint or by calling 1-855-427-5674, option 3.

Diabetic Services - Zero Dollar Cost Share

For Covered Persons with Type 1 or Type 2 diabetes, the following services and lab tests specifically used to assess lipid levels, kidney function (including metabolic and urine) and glucose control (HbA1c) in diabetics are offered at $0 cost share:

- Retinal eye exams, limited to one exam per plan year.
- Preventive foot care.
- Nutritional counseling.
- HbA1c screening.
- Kidney Health Evaluation for diabetes.
- Metabolic panels.
- Lipid panel.
- Urinalysis panel.

This does not apply to Covered Persons with pre-diabetes or gestational diabetes diagnoses.

Durable Medical Equipment (DME)

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

DME includes, but isn't limited to:

- Canes.
- Cochlear implants and batteries for cochlear implants.
- Commode chairs.
- Compression garments.
- Continuous glucose monitors.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.
- Hospital beds.
- Infusion pumps.
- Nebulizers.
- Oxygen equipment.
- Patient lifts.
- Pressure-reducing support surfaces.
- Suction pumps.
- Traction equipment.
- Walkers.
- Manual wheelchairs.

These Benefits apply to external DME that meets the following standards:

- Equipment that is Medically Necessary for the treatment of an illness or accidental injury or to prevent further deterioration.

- Equipment that is designed for repeated use, including oxygen equipment, functional wheelchairs, and crutches.
- Equipment that is considered standard and/or basic for the treatment of an illness or accidental injury as defined by nationally recognized guidelines.

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

Benefits are available for fitting, repairs and replacement, except as described in *Section 2: Exclusions and Limitations.*

Benefits include a one-month rental of a wheelchair if you own the wheelchair that is being repaired.

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

Emergency Health Care Services - Outpatient

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

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

Enteral Nutrition

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

Benefits include diagnosing, monitoring and controlling disorders by nutritional and medical assessment, including clinical services, biochemical analysis, prescription drugs, medical supplies, corrective lenses for conditions related to the metabolic diseases, nutritional management and Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

Enteral formulas or products, as nutritional support, are covered only when prescribed by a practitioner/provider and administered by enteral tube feedings. Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is covered when ordered by a practitioner/provider.

Benefits also include special medical foods for genetic inborn errors of metabolism or as Medically Necessary.

Benefits are subject to the terms and conditions of this Policy with respect to durational limits, dollar limits, deductibles, Co-insurance and Co-payments being applied the same as any other illness.

Gender Dysphoria

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

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

Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Policy. Benefits for medication available by a prescription or order or refill are provided under the *Outpatient Prescription Drugs* section of this Policy.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living. Habilitation services also include services that are required for the diagnosis and treatment of Covered Persons with Autism Spectrum Disorder. We, in consultation with your provider, will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Acupuncture services.
- Chiropractic services.
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

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

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

The following are not habilitative services:

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

We may require the following be provided:

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

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress we may request additional medical records.

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

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

Early Intervention Services

Benefits are provided for early intervention services provided to children, from birth through three years of age, who have been identified as having or at risk of having developmental delay or disabilities, for or under the *Family Infant Toddler Program* administered by the *New Mexico Department of Health.*

Services must be provided as part of an individualized family service plan designed to meet the developmental needs of the child and the needs of the family related to enhancing the child's development, and must be delivered by certified and licensed personnel who are working in early intervention programs approved by the *New Mexico Department of Health.*

Services include:

- Assistive technology.
- Audiological and vision.
- Speech and language pathology.
- Developmental consultation.
- Family training, including counseling and home visits.
- Social work.
- Nutritional.
- Health, medical and nursing services.
- Occupational and physical therapy services.
- Psychological services.
- Respite.
- Transportation.

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). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges 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. If you purchase a hearing aid that exceeds these minimum specifications, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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

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

Benefits are limited to a single purchase per hearing impaired ear every three years, including fitting and dispensing services, and providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser, or a Physician. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.

Home Health Care

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

- Provided on a written order of a licensed Physician, provided such order is renewed at least every 60 days.
- Provided directly or through contractual relationships by a Home Health Care Agency licensed in the state in which the home health services are delivered.

- Provided in your home by a registered nurse, or provided by a home health aide, home health therapist, including physical occupational or respiratory therapist, speech pathologist, or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Sickness or Injury requiring the Home Health Care.

Benefits include:

- Medical supplies, drugs and medicines and laboratory services, to the extent they would have been covered if provided to the Covered Person on an inpatient basis.
- Collection of specimens to be submitted to an approved laboratory facility for analysis.
- Medical equipment, prescription drugs and medications, laboratory services and supplies deemed Medically Necessary by a practitioner/provider for the provision of health services in the home, except Durable Medical Equipment.
- Total parenteral and enteral nutrition as the sole source of nutrition. See Benefits as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services.*
- Medical drugs (obtained through the medical Benefit): Medical drugs are defined as medications administered in the office, infusion suite, or facility (including home health care) that require a health care professional to administer. These medications include, but are not limited to, injectable, infused, oral or inhaled drugs. They may involve unique distribution and may be required to be obtained from our vendor. Infusion therapy is a Benefit covered under this section. See Benefits as described under *Pharmaceutical Products - Outpatient* in *Section 1: Covered Health Care Services.*

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

Benefits are limited to 100 days per year. One visit equals up to four hours of Skilled Care services.

Hospice Care

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

- Inpatient hospice care.
- Practitioner/provider visits by certified hospice practitioner/providers.
- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Home health care services by approved home health care personnel.
- Physical therapy.
- Medical supplies.
- Prescription drugs and medication for the pain and discomfort specifically related to the terminal illness.
- Medical transportation.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency or certified hospice practitioner/provider. When there is not a certified hospice program available, regular home health care services Benefits will apply. Respite care is not to exceed five continuous days for every 60 days of hospice care. No more than two respite care stays will be available during a hospice Benefit period.

Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Policy. Benefits for medication available by a prescription or order or refill are provided under the *Outpatient Prescription Drugs* section of this Policy.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

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).
- Acute medical detoxification. This does not include acute medical detoxification in a residential treatment center.
- Newborn care, including visits to the Hospital by the baby's practitioner/provider and incubators.
- Physician services for radiologists, anesthesiologists, pathologists and Emergent ER Services Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

For the treatment of breast cancer, Benefits also include Inpatient Stays as follows:

- 48 hours following a mastectomy.
- 24 hours following a lymph node dissection for the treatment of breast cancer.

An Inpatient Stay can be for a shorter period of time if the Physician and Covered Person agree it is appropriate.

Benefits include, but are not limited to, general nursing care, meals and special diets or parenteral nutrition when Medically Necessary, Physician and surgeon services, use of all Hospital facilities when use of such facilities is determined to be Medically Necessary by the Covered Person's Primary Care Physician or treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when Medically Necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when Medically Necessary.

Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits include, but are not limited to, the following:

- 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*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.
- Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition when the test is supported by medical and scientific evidence.
- Cervical cancer screening.
- Sleep disorder studies in the home or in a facility.
- Bone density studies.
- Gastrointestinal lab procedures.
- Pulmonary function tests.

- Mammography screening. Benefits for screening mammography for non-symptomatic Covered Persons as follows:
    - For a Covered Person who is at least 35 years of age, but under 40 years of age, one baseline screening mammography.
    - For a Covered Person who is at least 40 years of age, but under 50 years of age, one mammogram every two years. This is covered under *Preventive Care Services* without cost share.
    - For a Covered Person who is at least 50 years of age, an annual mammogram. This is covered under *Preventive Care Services* without cost share.

Network cost sharing is eliminated for low-dose supplemental and diagnostic breast exams.

"Supplemental breast exam" means a Medically Necessary and clinically appropriate exam of the breast using breast magnetic resonance imaging or breast ultrasound that is used to screen for breast cancer when there is no abnormality seen or suspected; and based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

"Diagnostic breast exam" means a Medically Necessary and clinically appropriate exam of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality that is seen or suspected from a screening examination for breast cancer; or detected by another means of examination.

Preventive screenings included in the comprehensive guidelines supported by the *Health Resources and Services Administration* are described under *Preventive Care Services.*

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

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

Major Diagnostic and Imaging - Outpatient

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

Benefits 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*.)
- Artery calcification testing.

Network cost sharing is eliminated for breast MRIs performed as part of supplemental or diagnostic breast exams as described under *Lab, X-ray and Diagnostic – Outpatient*.

Mental Health Care and Substance-Related and Addictive Disorders Services

The Mental Health/Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Mental Health and Substance-Related and Addictive Disorders Services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Care Services, you can contact the Delegate at the telephone number on your ID card.

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.

- Intensive Outpatient Program.
- Outpatient treatment.

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

Services include the following:

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

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

Benefits under this section include alcoholism services. Benefits are provided for Covered Health Care Services for care and treatment of alcohol dependency. Coverage also includes services received on an inpatient basis in an Alcohol Dependency Treatment Center and services received on an outpatient basis in a provider's office or at an Alternate Facility.

Your coverage complies with requirements under the federal Mental Health Parity and Addiction Equity Act, and with new sections of the New Mexico Insurance Code Chapter 59A, pursuant to Senate Bill 273, Parity for Coverage of Mental Health and Substance Use Disorder (MH/SUD) Services. For additional information on these requirements or if you feel your rights have been violated, you may contact the NM Office of Superintendent of Insurance using this link: https://www.osi.state.nm.us/

Your rights under these federal and state laws include:

- Generally, coverage in this plan does not impose stricter limitations or financial requirements to MH/SUD coverage than the limitations or financial requirements that are imposed on medical and surgical benefits.
- MH/SUD services that are offered must have treatment available in: psychiatry, psychology, social work, clinical counseling, addiction medicine counseling, and family and marriage counseling. These benefits are subject to network requirements, Provider scope of practice and credentialing, and may be subject to medical necessity review.
- Our authorization criteria must follow generally recognized standards of care established by evidence-based resources, including clinical practice guidelines and recommendations from MH/SUD care Provider professional associations and relevant federal government agencies.
- Federal and New Mexico law requires the plan not exclude coverage for MH/SUD services under the following circumstances:
    - Services that are available to you through federal or state laws for people with disabilities.
    - Services that are available to you through a public benefit program.
    - Services that have been court ordered and have been determined to be Medically Necessary by a Provider.
    - Services for individuals who have co-occurring diagnoses of mental health and substance use disorders.

- MH/SUD Provider network –
  - We maintain an adequate network as required by New Mexico state-mandated network adequacy standards of qualified MH/SUD services Providers.
  - If the eligible services cannot be provided within our network, you will not have to pay extra for eligible services if similar services under your benefit plan are provided by an out-of-Network Provider.
- Prior-authorization guidelines –
  - Certain types of services require prior-authorization by us.
  - Prior-authorization means that you or your Provider must ask us to approve the care before you receive it.
  - Prior-authorization cannot be taken back or changed after the Provider gives the services in good faith, except for cases of dishonesty, material misrepresentation, or violation of the Provider's contract.
  - We are prohibited from ordering prior-authorization or referral for in-network service coverage for: acute or immediately necessary care, acute episodes of chronic MH/SUD conditions, initial in-Network inpatient or outpatient SUD services.
  - Prior-authorization will be determined in discussion with your MH/SUD Provider for continuation of services, unless your eligibility in the plan ends.
  - Coverage for medication must be made according to a medical need.
  - For SUD medications, we cannot require prior-authorization or "step-therapy" (such as making you take additional steps before paying for medication prescribed by your Provider), unless there is a generic or a biosimilar (which means a biological medicine approved by the *U.S. Food and Drug Administration* or *FDA* that works in a similar way to its reference drug) equivalent.
- After beginning in-network MH/SUD treatment, we may require your Provider to notify us and/or develop and submit a treatment plan for continued treatment/services.
- We cannot limit coverage for MH/SUD services up to the point of relief of presenting signs and symptoms or to short-term care or acute treatment.
- Your length of time for treatment will be based on your Provider's recommendation and MH/SUD needs, which may be assessed in conjunction with accepted clinical practice guidelines and recommendations.
- Level of care determinations:
  - Level of care means the treatment setting or facility type that is most appropriate to treat your condition.
  - Your MH/SUD Provider decides, in consultation with the health plan, what types of services you need and for how long, based on your diagnosis and generally recognized standards of care.
  - Services may include placement into a facility that provides detoxification services, a Hospital, an in-patient rehabilitation treatment facility or outpatient treatment program.
  - Changes in level and length of time of care will be determined by your Provider in consultation with the health plan and based on assessments of medical necessity using accepted clinical practice guidelines.
- At your request, we will provide coordination of care which means we may help communication between your MH/SUD service Provider and your primary care Provider to prevent any conflicts of care that could be harmful to you.
- We will make sure our MH/SUD policies are available to you.
- We protect your confidentiality when receiving MH/SUD treatment.
- We will not end coverage of your treatment without a discussion with your MH/SUD Provider and you.
- If your claim is denied due to lack of "medical necessity," you have a right to request the specific reasons for your denial.

For the purposes of this section, "mental health or substance use disorder services" means:

- Professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder; or
- Professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act.

No Cost Sharing for Behavioral Health Services

Network cost sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, substance use disorders and trauma spectrum disorders. This includes cost sharing for inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all behavioral health medications, as described under the *Outpatient Prescription Drugs* section, including brand-name pharmacy drugs when generics are unavailable.

In addition, cost sharing would not apply if:

- Reimbursement for the service is governed by the Surprise Billing Act; or
- The plan specifically authorized the Out-of-Network Provider to deliver the service(s) when care is not available from a Network provider.

"Cost sharing" means any Co-payment, Co-insurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations.

Zero cost share applies to Behavioral Health Services received from a Network Provider only.

We do not impose quantitative treatment limitations or financial limitations on covered mental health or substance use disorder services that are more restrictive than the predominant restrictions or limitations on substantially all of the covered medical/surgical benefits.

We do not impose non-quantitative treatment limitations on covered mental health or substance use disorder services that are more restrictive than covered medical/surgical health benefits.

We review utilization review processes, at least monthly, to reflect the most recent evidence and generally recognized standards of care.

Morbid Obesity Surgery

The plan covers surgical treatment of morbid obesity provided all of the following are true:

- For adolescents, you have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a minimum Body Mass Index (BMI) of 40, or > 35 with at least 1 co-morbid condition present.
- You must enroll in the *Optum Bariatric Resource Services (BRS)* program, a surgical weight loss solution for those individual(s) who qualify clinically for Morbid Obesity Surgery.
- Excess skin removal post bariatric surgery is not covered, unless Medically Necessary.

Necessary Medical Supplies

Medical Supplies that are used with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., oxygen tubing or mask, batteries for power wheelchairs and prosthetics, or tubing for a delivery pump, or lymphedema wraps or garments).

Benefits also include surgical dressings that require a practitioner's/provider's prescription, and cannot be purchased over-the-counter, when Medically Necessary for the treatment of a wound caused by, or treated by, a surgical procedure.

Benefits include gradient compression stockings for:

- Severe and persistent swollen and painful varicosities, or lymphedema/edema or venous insufficiency not responsive to simple elevation; and

- Venous stasis ulcers that have been treated by a practitioner/provider or other health care professional requiring medically necessary debridement (wound cleaning).

Orthotics

Orthotic devices means rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part.

Orthotic braces, including needed changes to shoes to fit braces, braces that stabilize an injured body part, braces to treat curvature of the spine, and braces and other external devices used to correct a body function including clubfoot deformity are a Covered Health Care Service.

Benefits are available for fitting, repairs and replacement, except as described in *Section 2: Exclusions and Limitations.*

Please see *Medical Necessity and Nondiscrimination Standards for Coverage of Prosthetics and Orthotics* under *Prosthetic Devices* for information on standards of coverage of custom orthotics.

Pharmaceutical Products - Outpatient

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

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

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we may direct your Physician to a Specialty Dispensing Entity. Such Specialty Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Specialty Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Specialty Dispensing Entity, Benefits are not available for that Pharmaceutical Product, unless the provider or its intermediary agrees in writing to accept reimbursement, including Co-payment, at the same rate as a Specialty Dispensing Entity.

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

We may have certain programs in which you may receive an enhanced 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 by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Physician Fees for Surgical and Medical Services

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

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 regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Services can be provided by practitioners/providers in a medical group, independent practice association, or other authority authorized by applicable state law.

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

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

Covered Health Care Services include:

- Genetic Counseling.
- Allergy testing and injections.
- Second medical opinions.
- Wound care.
- Medical nutrition therapy provided by a licensed dietician or nutritionist, working in coordination with a Physician, to treat a chronic illness or condition. Nutritional supplements administered by injection at the practitioner's/provider's office are covered when Medically Necessary.
- Well-baby and well-child screening for the diagnosis and presence of Autism Spectrum Disorder.
- Wound care.
- Glaucoma eye test.
- Remote Physiologic Monitoring services.
- Diagnosis and treatment of the underlying causes of infertility. Depending on where a service is received, Benefits will be provided under the corresponding Benefit category in this Policy.
- Hypnotherapy is covered only when performed by an anesthesiologist or psychiatric practitioner/provider, trained in the use of hypnosis when Medically Necessary or when used within two weeks prior to surgery for chronic pain management and for chronic pain management when part of a coordinated treatment plan. Anesthesiologist services are described under *Anesthesia*.
- Dietary evaluations and counseling for the medical management of morbid obesity and obesity. Prescription drugs that are Medically Necessary for the treatment of obesity are covered under the *Outpatient Prescription Drugs* section. See also Benefits described under *Morbid Obesity Surgery*.
- Osteoporosis services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- Urinary incontinence screening.

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

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

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office are described under *Lab, X-ray and Diagnostic - Outpatient.*

Student health centers: Dependent students attending school either in New Mexico or outside New Mexico may receive care through their Primary Care Physician or at the student health center. Services provided outside of the student health center are limited to important Medically Necessary covered services for the initial care or treatment of an Emergency Health Care Service or Urgent Care situation.

A pharmacist may order, test, screen, treat and provide preventive services for health conditions or situations that include:

- Influenza;
- Group A streptococcus pharyngitis;
- SARS-COV-2;
- Uncomplicated urinary tract infection;

- Human immunodeficiency virus, limited to the provision or pre-exposure prophylaxis and post-exposure prophylaxis; and
- Other emerging and existing public health threats identified by the Board or Department of Health during civil or public health emergencies.

Medications are covered under the *Outpatient Prescription Drugs* section of this Policy.

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 Care Services include related tests and treatment.

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

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

We will pay Benefits for a longer stay if it is Medically Necessary.

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

If the mother and newborn child are discharged earlier than the minimum time frames listed above, Benefits for postpartum care will be provided for a minimum of three home visits, unless the mother and the attending provider agree that one or two home visits are sufficient.

The home visits for postpartum care must be provided by a person with appropriate licensure, training, and experience to provide postpartum care.

Benefits are included for, but not limited to, the following services:

- Parent education.
- Assistance and training in breast and bottle feeding.
- The performance of any necessary and appropriate clinical tests.
- Nutritional supplements for prenatal care when prescribed by a practitioner/provider are covered for pregnant women.

In addition to the above services, Benefits include:

- Alpha-fetoprotein IV screening tests to screen for genetic abnormalities in the fetus that are generally given between week 16 and 20 of Pregnancy.
- Circumcision of a newborn male baby.
- Coverage of Injury or sickness including the necessary treatment of medically diagnosed congenital defects and birth abnormalities and, where necessary to protect the life of the infant, transportation, including air transport, to the nearest available Tertiary Care Facility for newly born infants. Depending on where a service is received, Benefits will be provided under the corresponding Benefit category in this Policy.

Preventive Care Services

Preventive care services provided on an outpatient basis at no cost to the Covered Person when received at a Network 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. Benefits may be subject to age and other health factors and can change to coincide with federal government changes:

- 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.* Key screenings and services include:
  - Preventive physical examinations.
  - Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam.
  - Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractioned cholesterol level including Low-Density Lipoprotein (LDL) and High-Density Lipoprotein (HDL) level.
  - Periodic stool examination for the presence of blood.
  - Colorectal cancer screening in accordance with the evidence-based recommendations established by the *United States Preventive Services Task Force* for determining the presence of pre-cancerous or cancerous conditions and other health problems including:
    - Fecal occult blood testing (FOBT).
    - Flexible Sigmoidoscopy.
    - Colonoscopy.
    - Virtual colonoscopy.
    - Double contrast barium enema.

    A follow-up colonoscopy is covered after a positive non-invasive stool-based screening test or direct visualization screening test.
  - Smoking Cessation Program.
  - Screening to determine the need for vision and hearing correction.
  - Periodic glaucoma eye test.
  - Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, HIV and sexually transmitted infections, as well as counseling for drug and tobacco use, health eating and other common health concerns.
  - Health education and consultation from practitioners/providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. Health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles, and other preventive health care practices.
  - Screening for Latent Tuberculosis Infection in adults.
  - Screening for anxiety in children and adolescents.
  - Screening and intervention for the prevention of dental caries in children younger than 5 years.
  - Screening for Abdominal Aortic Aneurysm.
  - Preventive interventions for Perinatal Depression.
  - Screening, behavioral counseling, and interventions for unhealthy alcohol use in children, adolescents and adults.
  - Screening for osteoporosis to prevent fractures.
  - Interventions to prevent falls in community-dwelling older adults.
  - Behavioral counseling for skin cancer prevention.
  - Screening for preeclampsia.
  - Preventive medications as follows:
    - Statin use for the primary prevention of cardiovascular disease in adults.

- Aspirin use to prevent preeclampsia and related morbidity and mortality.
- Ocular prophylaxis for Gonococcal Ophthalmia Neonatorum.
- Folic Acid for the prevention of Neural Tube Defects.

- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention,* the *American Academy of Pediatrics,* and the *United States Preventive Services Task Force.*
- HPV vaccine coverage for the human papillomavirus as approved by the *United States Food and Drug Administration (FDA)* and in accordance with all applicable federal and state requirements and the guidelines established by the *Advisory Committee on Immunization Practices (ACIP).*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*. Benefits include:
  - Annual physical exams.
  - Newborn, well-baby and well-child visits.
  - Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sports, school, or camp activities.
  - Hearing and vision screening for correction. This does not include routine eye exams or eye vision and hearing screening to determine refractions performed by eye care specialists. One eye refraction per calendar year is covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases.
  - Pediatric Vision, including routine eye care and glasses. For additional services, please see *Section 12: Pediatric Vision Care Services*.
  - Behavioral assessments.
  - Screening for autism, alcohol use, tobacco use, drug use, anemia, blood pressure, bilirubin concentration for newborns, congenital hypothyroidism, depression, developmental development and surveillance dyslipidemia, hematocrit/hemoglobin or sickle cell, lead, obesity, oral health, sexually transmitted diseases, Phenylketonuria (PKU) and Tuberculin.
  - Counseling from practitioners/providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. As deemed appropriate by the Covered Person's practitioner/provider or as requested by the parents or legal guardian, education information on alcohol and substance use, sexually transmitted diseases, and contraception.
  - Gonorrhea preventive medication for eyes of newborns.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.* Benefits include well-woman preventive visits; screening and counseling for domestic and interpersonal violence; anxiety screening for adolescent and adult women; and screening for urinary incontinence.
  - Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery. This includes one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

    - Which pump is the most cost-effective.

        - Whether the pump should be purchased or rented (and the duration of any rental).
        - Timing of purchase or rental.
    - Contraception: *United States Food and Drug Administration*-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
        - Includes methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices.
    - Counseling for HIV and sexually transmitted diseases.
    - Domestic and interpersonal violence screening and counseling for all women.
    - Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
    - Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
    - Human Papillomavirus (HPV) DNA test: High risk HPV DNA testing every three years for women with normal cytology results.
    - Screening and counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility.
    - Sexually Transmitted Infections (STI) counseling for sexually active women.
    - Sterilization services for women.
    - Well-woman visits to obtain recommended preventive services for women.
    - Cervical cancer screening.
    - Mammography screening. Benefits for screening mammography for non-symptomatic Covered Persons as follows:
        - For a Covered Person who is at least 35 years of age, but under 40 years of age, one baseline screening mammography.
        - For a Covered Person who is at least 40 years of age, but under 50 years of age, one mammogram every two years.
        - For a Covered Person who is at least 50 years of age, an annual mammogram.
- Voluntary male sterilization and associated anesthesia.

Contraceptive Coverage

You are entitled to receive certain covered contraception services and supplies without cost sharing and without prior approval from us. This means that you do not have to make a Co-payment, Co-insurance, satisfy a deductible or pay out-of-pocket for any part of contraception Benefits listed in this summary if you receive them from a Network provider.

You may be required to pay a Co-payment, Co-insurance, and/or a deductible if you receive a contraception service or supply from an out-of-network provider if the same service or supply is available in-Network. You may also owe cost sharing if you receive a brand-name contraceptive when at least one generic or a therapeutic equivalent is available.

Covered Contraceptive Methods

- Sterilization Surgery for Women
- Sterilization Surgery for Men
- IUD Copper
- IUD with Progestin
- Implantable Rod
- Shot/Injection

- Oral Contraceptives (The Pill) (Combined Pill)
- Oral Contraceptives (Extended/Continuous Use)
- Oral Contraceptives (Mini Pill – Progestin Only)
- Patch
- Vaginal Contraceptive Ring
- Diaphragm with Spermicide
- Sponge with Spermicide
- Cervical Cap with Spermicide
- Male Condom
- Female Condom
- Spermicide
- Emergency Contraceptive – "Plan B"
- Emergency Contraceptive – "Ella"

Long Acting Reversible Contraceptives

The Long Acting Reversible Contraceptives (LARCs), including Intrauterine Devices (IUDs) covered without cost-sharing by your plan are listed here: https://www.uhc.com/content/dam/uhcdotcom/en/Pharmacy/PDFs/2024-IFP-Plans-Contraceptives-Flyer.pdf. Coverage with no cost-sharing also applies to IUD insertion and removal, including surgical removal, and to any related medical examination when services are obtained from a Network provider. Coverage of LARCs with no cost-sharing also includes (pre-discharge) post-partum clinical services.

Oral Contraceptives

The oral contraceptives covered by your plan are listed here: https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists/individual-exchange.

Six Month Dispensing

You are entitled to receive up to a six-month supply of contraceptives, if prescribed and self-administered, when dispensed at one time by your pharmacy. If you need to change your contraceptive method before the six-month supply runs out, you may do so without cost-sharing. You will not owe cost sharing for any related contraceptive counseling or side-effects management.

Brand Name Drugs or Devices

Your plan may exclude or apply cost sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Please see the table of contraceptive categories above. Ask your provider about a possible equivalent.

Non-Covered Contraceptives

If your provider determines that a non-covered contraceptive is Medically Necessary, your provider may ask us to cover that contraceptive without cost-sharing. If we deny the request, you or your provider can submit a grievance to contest that denial. If your health care provider determines that the use of a non-covered contraceptive is Medically Necessary, the health care provider's determination will be final.

Vasectomies and Male Condoms

This plan covers vasectomies and male condoms. No prescription or cost sharing is required for coverage of male condoms. Please see the section below on *Coverage for Contraception Where a Prescription Is Not Required* for instructions on reimbursement for condoms.

Sexually Transmitted Infections

Your plan covers, and no cost sharing applies to, contraception methods that are prescribed for the prevention of sexually transmitted infections. Sexually transmitted infections mean chlamydia, syphilis, gonorrhea, HIV and relevant types of hepatitis, as well as any other sexually transmitted infection regardless of mode of transportation, as designated by rule upon making a finding that the particular sexually transmitted infection is

contagious. Treatment means Medically Necessary care for the management of an existing sexually transmitted infection.

Coverage for Contraception Where a Prescription Is Not Required

Your plan covers contraception with no cost sharing even when a prescription is not required. Contraceptive methods such as condoms or Plan B may fall into this category. You will not have to pay upfront for contraceptives that do not require a prescription when obtained through a Network pharmacy. For all other purchases, you may submit a request for reimbursement as follows:

- Within 90 days of the date of purchase of the contraceptive method,
- Provide the receipt with the item name and amount, your name, address, plan ID number, to the following:

  OptumRx Claims Department

  PO Box 650334

  Dallas, TX 75265-0334

  Or,

- Provide the receipt with the reimbursement form available at www.myuhc.com/exchange, to the following:

  OptumRx Claims Department

  PO Box 650334

  Dallas, TX 75265-0334

If you submit your complete request for reimbursement electronically or by fax, we will reimburse you within 30 days of receiving the request. If you submit your complete request for reimbursement by U.S. mail, we will reimburse within 45 days. Failure to submit a complete request may lead to delays in reimbursement.

Availability of Out-of-Network Coverage

Under your plan, use of an Out-of-Network Provider to prescribe or dispense contraceptive coverage is not a covered Benefit.

Tobacco Cessation Treatment

Benefits are provided for the following:

- Diagnostic services necessary to identify tobaccos use or use-related conditions and dependence.
- Pharmacotherapy, as described under the *Outpatient Prescription Drugs* section including all FDA approved tobacco cessation medications (including both prescription and over-the-counter medications) for two 90-day treatment regimens per calendar year when prescribed by a health care provider.
- Cessation counseling. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization.
- Initiation of any course of pharmacotherapy or cessation counseling shall constitute an entire course regardless if the Covered Person discontinues or fails to complete the course.

For purposes of this Benefit, "Cessation counseling" means a program, including individual, group, or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides counseling at a minimum on establishment of reasons for quitting tobacco use, understanding nicotine addiction, various techniques for quitting tobacco use and remaining tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow-up.
- Operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying enrollee attendance.

- Employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities.
- Uses a formal evaluation process, including mechanisms for data collections and measuring participant rate and impact of the program.

Pre-Exposure Prophylaxis (PrEP)

Your plan includes coverage for PrEP medication, as appropriate for you, and essential PrEP related services without cost-sharing, the same as any other preventive drug or service. This means that you do not have to make a Co-payment, pay Co-insurance, satisfy a deductible or pay out-of-pocket for any part of the Benefits and services listed in this summary if you receive them from a Network provider.

You may be required to pay a Co-payment, Co-insurance, and/or deductible if you receive PrEP medication or PrEP related services from an out-of-network provider if the same benefit or service is available from a Network provider.

What is Covered?

- At least one FDA-approved PrEP drug, with timely access to the PrEP drug that is medically appropriate for the enrollee, as needed, is available under the *Outpatient Prescription Drugs* section.
- HIV testing.
- Hepatitis B and C testing.
- Creatinine testing and calculated estimated creatine clearance or glomerular filtration rate.
- Pregnancy testing for individuals with childbearing potential.
- Sexually transmitted infection screening and counseling.
- Adherence counseling.
- Office visits associated with each preventive service listed above.
- Quarterly testing for HIV and STIs, and annually for renal functions, required to maintain a PrEP prescription.

PrEP Grievance and Appeals Process

If you were charged cost-sharing for coverage of PrEP medication or PrEP related services on or after January 1st, 2021, please call our customer service line at 866-569-3491 or follow the grievance process found in *Section 6: Summary of Health Insurance Grievance Procedure* if the issue is not resolved at the customer service level.

If you are denied coverage of a PrEP related service(s), we will inform you in writing of the denial. Our notice to you will explain why we denied the coverage and will provide you with instructions for filing a grievance if you want to contest our decision. You, your designee, prescribing physician or other prescriber can request a standard or expedited review of a PrEP coverage denial.

The insurer provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the insurer's consumer assistance office as follows:

Medical Appeal	UnitedHealthcare Appeals & Grievances PO Box 6111 Mail Stop CA-0197 Cypress, CA 90630 Telephone: 1-866-842-9268 Fax: 1-888-404-0949 www.myuhc.com/exchange
Prescription Drug Appeal	OptumRx c/o Appeals Coordinator PO Box 2975 Mission, KS 66201 Telephone: 1-888-403-3398 Fax: 1-877-239-4565

PrEP Exception Process

If you have been denied coverage of a PrEP medication, we will inform you in writing of the denial. Our notice to you will provide you with instructions for filing an exception request if the medication that is most appropriate for your circumstances is not included in the drug formulary. You, your designee, prescribing physician or other prescriber can request a standard or expedited review of a PrEP medication coverage denial. To make a request, contact us in writing, electronically at www.myuhc.com/exchange or call the toll-free number on your ID card.

PrEP Standard Review

We will review your request and issue a determination to you, your designee, prescribing physician or other prescriber, within 72 hours following receipt of your request.

PrEP Expedited Review

If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a non-formulary drug, you can request an expedited review. We will review your request and issue a determination to you, your designee, prescribing physician or other prescriber, within 24 hours following receipt of your request. If our initial determination is overturned, we will provide coverage for the PrEP medication or PrEP related service that is medically appropriate for you for the duration of the treatment.

For more information or assistance with your complaint, grievance or an exception request, you may contact the Managed Health Care Bureau (MHCB), of the Office of Superintendent of Insurance at:

Telephone: 1-505-827-4601 or toll free at 1-833-415-0566

Address: Office of Superintendent of Insurance - MHCB

P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689

FAX #: (505) 827-4734, Attn: MHCB

E-mail: mhcb.grievance@state.nm.us

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.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Two bras per year are covered for Covered Persons with external breast prosthesis.
- Penile prosthesis.
- Joint replacements.
- Heart pacemakers.
- Tracheostomy tubes.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this Policy.

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

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

Medical Necessity and Nondiscrimination Standards for Coverage of Prosthetics and Orthotics

This plan provides coverage for initial and secondary prosthetic devices and custom orthotics in a non-discriminatory manner, and without restriction based on predetermined utilization limits, at the same level and cost-sharing as the coverage provided for medical and surgical benefits. Prosthetic and custom orthotic devices are considered habilitative and rehabilitative essential health benefits and are not subject to separate financial requirements or utilization restrictions.

Coverage includes:

- Clinical care;
- All supplies, materials, and devices determined by the physician to be medically necessary and most appropriate to maximize upper and lower limb function, maintain activities of daily living or essential job-related activities, and meet the medical needs for physical activities such but not limited to running, biking, swimming strength training;
- All services, including design, fabrication and repair;
- Replacement without regard to reasonable useful lifetime restrictions, including replacement necessary due to a change in the patient's condition or the condition of the device if replacement the device requires repairs costing more than 60 percent of replacement cost; and
- Access to prosthetic and custom orthotic devices from at least two distinct device providers in your network

Utilization management decisions related to coverage for prosthetic or custom orthotic devices will be applied in a non-discriminatory manner using the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Prosthetic and custom orthotic benefits will not be denied for an individual with limb low or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same daily functions and physical activity. However, coverage for prosthetic devices and custom orthotics will not be provided when required solely for comfort or convenience.

Reconstructive Procedures

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

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

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

Cosmetic Procedures are excluded from coverage. Cosmetic Procedures do not include reconstructive procedures for treatment of a Congenital Anomaly of a newborn child. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. Benefits include reconstruction procedures for the treatment of gender dysphoria when meeting the applicable criteria.

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

Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Acupuncture services.
- Chiropractic services.
- Pulmonary rehabilitation services for progressive exercises and monitoring of pulmonary functions.
- Cardiac rehabilitation services for continuous electrocardiogram (ECG) monitoring, progressive exercises and intermittent ECG monitoring.

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

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

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

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

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

Massage therapy is only covered when provided by a licensed physical therapist and as part of prescribed short-term rehabilitation physical therapy program.

Cost share for physical rehabilitation services will not be greater than that for primary care services on a Co-insurance percentage basis when Co-insurance is applied or on an absolute dollar amount when a Co-payment is applied.

Rehabilitation services also include services that are required for treatment or rehabilitation of individuals with Autism Spectrum Disorder and include treatment through speech therapy, occupational therapy, physical therapy and *Applied Behavioral Analysis.*

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

- 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*.)

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

Colorectal Screenings

Benefits include:

- Colorectal screenings for determining the presence of precancerous or cancerous conditions and other health problems.
- Specialist consultation prior to the screening procedure to determine if the patient is healthy enough for the procedure and to explain the process to the patient, including required preparation.
- Polyp removal during a colonoscopy.

- Any pathology exam on a polyp biopsy after the colonoscopy.
- Anesthesia.

Colorectal cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* are described under *Preventive Care Services.*

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 first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

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

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

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Benefits are not available for services in a Long-term Acute Care Facility (LTAC).

Skilled Care in a Skilled Nursing Facility is limited to 60 days per calendar year.

Surgery - Outpatient

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

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Benefits include:

- Sleep apnea procedures.
- Major endoscopic procedures.
- Operative and cutting procedures.
- Preoperative and postoperative care.
- Observation following outpatient services.
- 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*.)

Tissue transplants and cornea transplants when ordered by a Physician. Benefits are available for tissue and cornea transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service. You can call us at the telephone number on your ID card for information regarding Benefits for tissue and cornea transplant services.

Outpatient Facility Fees

You are required to seek services from Network Providers unless prior approval has been obtained to receive services from an out-of-Network Provider. In the case of approved out-of-Network care, you would be responsible for paying any Co-payment, deductible, or Co-insurance percentage as if the same care was received from a Network Provider or Network facility. Network Providers and Network facilities are responsible for confirming coverage and are prohibited from balance billing you. Network facilities and Network Providers would determine what is covered prior to the procedure. The Network Provider and Network facility may only charge you for your cost share as listed in the *Summary of Benefits and Coverage (SBC)*. An *Explanation of Benefits (EOB)* is available to your after the claim is processed, and you can contact us or your Provider with any questions.

Many of our Provider contracts utilize *Ambulatory Payment Classification (APC)* reimbursement methodology and would calculate facility fees according to CMS *Outpatient Prospective Payment System (OPPS)* guidelines. Other contracts utilize packaged fixed rates, i.e. Per Case Methodology, which would also reimburse the same amount for a single case. It is common practice for a facility to post a notification to patients at the place where they receive services, if a facility fee may be assessed.

Telemedicine Services

Benefits are provided for services delivered via Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Summary of Benefits and Coverage ("SBC")*.

"Telemedicine" means the use of telecommunications and information technology to provide clinical health care from a distance. Telemedicine allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver health care services to a site where the patient is located, along with the use of electronic media and health information. Telemedicine allows patients in remote locations to access medical expertise without travel. Telemedicine does not include virtual care services provided by a Virtual Network Provider.

Temporomandibular Joint Syndrome (TMJ) and Craniomandibular Disorder Services

Benefits include charges for Covered Health Care Services to diagnose and treat temporomandibular joint and craniomandibular disorders.

Benefits include services for diagnostic and surgical treatment that is recognized by us as a generally accepted form of care or treatment, according to prevailing standards of the medical and dental practice profession as effective and appropriate for the diagnosis and surgical treatment of temporomandibular joint and craniomandibular disorders.

Benefits for non-surgical treatment of temporomandibular joint and craniomandibular disorders include intra-oral splints that stabilize or reposition the jaw joint and physical therapy.

Benefits do not include charges that are incurred for any service related to fixed or removable appliances that involve movement or repositioning of the teeth, occlusal (bite) adjustments, treatment of malocclusion, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures, dental implants).

Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Policy. Benefits for medication available by a prescription or order or refill are provided under the *Outpatient Prescription Drugs* section of this Policy.

Therapeutic Treatments - Outpatient

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

- Dialysis (both hemodialysis and peritoneal dialysis).

- Intravenous Chemotherapy or other intravenous infusion therapy.
- Radiation oncology.
- Hyperbaric oxygen therapy is a Covered Health Care Service when Medically Necessary and only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the *Hyperbaric Oxygen Therapy Committee* of *The Undersea and Hyperbaric Medical society (UHMS).*

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

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

Benefits include:

- 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*.

Transplantation Services

Organ transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service. “Organ transplant” includes parts or the whole of organs, eyes or tissue.

Examples of transplants for which Benefits are available include, but are not limited to:

- Bone marrow transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high dose chemotherapy. Bone marrow transplants are covered for the following indications:
  - Multiple myeloma.
  - Leukemia.
  - Aplastic anemia.
  - Lymphoma.
  - Severe combined immunodeficiency disease (SCID).
  - Wiskott Aldrich syndrome.
  - Ewings Sarcoma.
  - Germ cell tumor.
  - Neuroblastoma.
  - Wilm’s Tumor.
  - Myelodysplasatic syndrome.
  - Myelofibrosis.
  - Sickle cell disease.
  - Thalassemia major.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.

- Liver.
- Liver/small intestine.
- Meniscal Allograft.
- Multi-visceral (3 or more abdominal organs).
- Pancreas.
- Pancreas islet cell infusion.
- Small intestine.
- Simultaneous multi-organ transplants - unless Investigational.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under this Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

To receive Benefits for transplantation services, it is important that we, in consultation with your provider, assist you with locating a Network Transplant Provider for care.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

We will not:

- Deny coverage solely on the basis of a Covered Person’s physical or mental disability.
- Deny to a Covered Person with a physical or mental disability eligibility or continued eligibility to enroll or to renew coverage under the terms of this health Benefit Policy.
- Penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a health care provider to induce that health care provider not to provide an organ transplant or associated care to a Covered Person with a physical or mental disability.
- Reduce or limit coverage Benefits to a Covered Person with a physical or mental disability for the associated care related to organ transplantation as determined in consultation with the Physician and patient.

Travel and Lodging

Benefits include transportation and lodging for the covered patient receiving transplant and a companion up to a maximum of $150 per day. If the recipient of the transplant is a dependent child under the limiting age of this Policy, Benefits for transportation and lodging will be provided for the transplant recipient and two companions.

For Benefits to be available, the patient’s place of residency must be more than 50 miles from the Hospital where the transplant will be performed. This applies to both in-state and out-of-state transplants.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*. If you receive a Covered Health Care Service from an Out-of-Network urgent care provider, when reasonable access to a Network urgent care provider is not available, we will reimburse the Out-of-Network urgent care provider at the same level of Benefits as the Network urgent care provider. Reasonable access to a Network urgent care provider means a distance of 20 miles from the Covered Person's residence.

Urgent care services include acute medical care that is available twenty-four hours per day, seven days per week, so as not to jeopardize a Covered Person’s health status if such services were not received immediately; such medical care includes ambulance or other emergency transportation; in addition, acute medical care includes,

where appropriate, transportation and indemnity payments or service agreements for out-of-service area or out-of-network coverage in cases where the Covered Person cannot reasonably access in-network services or facilities.

Virtual Care Services

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

Benefits are available only when services are delivered through a Virtual Network Provider. You can find a Virtual Network Provider by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Benefits are available for urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

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

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

Vision Services

Covered Health Care Services include Medically Necessary services provided for the initial prescription for corrective lenses (eyeglasses or contact lenses) and frames within 12 months after cataract surgery.

Benefits for contact lenses will be provided if a Covered Person's visual acuity cannot be corrected to 20/70 in the better eye except for the use of contact lenses.

Except as described above, Benefits are not available for any prescription corrective lenses (eyeglasses or contact lenses) or frames following post-cataract surgical service. Examples include, but are not limited to: coated lenses, cosmetic contact lenses, no-line bifocal or trifocal lenses, oversize lenses, plastic multi-focal lenses, tinted or photochromic lenses, prescription sunglasses.

Eyeglasses and contact lenses (Limited) will only be covered under the following circumstances:

- Contact lenses are covered for the correction of aphakia (those with no lens in the eye) or keratoconus. This includes the eye refraction examination.
- Genetic Inborn Errors of Metabolism: Benefits are provided for one pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) within 12 months after cataract surgery or when related to genetic inborn error of metabolism. This includes the eye refraction examination, lenses and standard frames.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

Alternative Treatments

1. Aromatherapy.
2. Hypnotism, except as described under *Anesthesia* in *Section 1: Covered Health Care Services*.
3. Massage therapy, except when provided by a licensed physical therapist and as part of prescribed short-term rehabilitation physical therapy program.
4. Rolfing.
5. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
6. Art therapy, music therapy, dance therapy, animal assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

1. Dental care (which includes dental X-rays and other imaging studies, supplies and appliances and all related expenses, including hospitalizations and anesthesia), except as described under *Dental Anesthesia* and *Dental Services* in *Section 1: Covered Health Care Services*.

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

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

   - Transplant preparation.

- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of cancer or cleft palate.
- Dental anesthesia for which Benefits are provided as described under *Dental Anesthesia* in *Section 1: Covered Health Care Services*.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums except as provided under *Dental Services* in *Section 1: Covered Health Care Services*.

   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 does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services* in *Section 1: Covered Health Care Services*.

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

Devices, Appliances and Prosthetics

1. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Diabetes Services*, *Durable Medical Equipment (DME),* and *Orthotics* in *Section 1: Covered Health Care Services.* This exclusion does not apply to orthotics covered as required under the *Medical Necessity and Nondiscrimination Standards for Coverage of Prosthetics and Orthotics* section.
2. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
3. Devices and computers to help in communication and speech.
4. Oral appliances for snoring.
5. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
6. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
7. Powered and non-powered exoskeleton devices.
8. Powered wheelchairs.
9. Wigs.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. See the *Outpatient Prescription Drugs* section of this Policy for prescription drug products covered under the pharmacy benefit.
2. Self-administered or self-infused medications that are covered under the *Outpatient Prescription Drugs* section. This exclusion does not apply to medications which, due to their traits (as determined by us in consultation with your provider), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to insulin as described under the *Outpatient Prescription Drugs* section.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments, except FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) as described under the *Outpatient Prescription Drugs* section.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness of condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to monthly.
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 monthly.
9. 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 monthly.
10. 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 monthly.
11. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

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

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

Foot Care

1. Routine foot care. Examples include:

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

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Foot orthotics, orthopedic shoes, inserts, modifications, and footwear except as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
5. Arch supports.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings, except as described under *Durable Medical Equipment (DME)* in *Section 1: Covered Health Care Services.*
   - Ace bandages.
   - Gauze and dressings.
   - Items routinely found in the home.
   - Ostomy Supplies.
   - Urinary catheters.

   This exclusion does not apply to:
   - Surgical dressings or disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME)* and *Prosthetic Devices* in *Section 1: Covered Health Care Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Tubings except when used with DME as described under *Durable Medical Equipment (DME)* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

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 under *Preventive Care Services* in *Section 1: Covered Health Care Services* or nutritional counseling as described under *Physician's Office Services – Sickness and Injury* in *Section 1: Covered Health Care Services*. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services.*

3. Nutritional or dietary supplements, except as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist, or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. This exclusion does not apply to:

   - Nutritional supplements for prenatal care of pregnant women when prescribed by a practitioner/provider.
   - Nutritional supplements that require a prescription to be dispensed are covered when prescribed by a practitioner/provider and when Medically Necessary to replace a specific documented deficiency.
   - Nutritional supplements administered by injection at the practitioner's/provider's office are covered when Medically Necessary.

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.

Physical Appearance

1. Cosmetic Procedures when not determined to be Medically Necessary. See the definitions in *Section 8: Defined Terms*. Examples include:
   - Membership costs and fees for health clubs and gyms. This exclusion does not apply to incentives provided as described under the heading *Are Incentives Available to You?* in *Section 7: General Legal Provisions*.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
   - Abdominoplasty.
   - Blepharoplasty.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.

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

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. This exclusion does not apply to Medically Necessary panniculectomy.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
7. Biofeedback except for the treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.
8. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.
9. Breast reduction and augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
10. Helicobacter pylori *(H. pylori)* serologic testing.
11. Intracellular micronutrient testing.
12. Morbid obesity surgery not received from a provider through the *Optum Bariatric Resource Services* program.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services 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 a diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services performed for the diagnosis and treatment of any underlying cause of infertility as described under *Physician's Office Services – Sickness and Injury* in *Section 1: Covered Health Care Services.*
2. The following services related to a Gestational Carrier or Surrogate:

- All costs related to reproductive techniques including:
  - Assisted reproductive technology.
  - Artificial insemination.
  - Intrauterine insemination.
  - Obtaining and transferring embryo(s).
- Health care services including:
  - Inpatient or outpatient prenatal care and/or preventive care.
  - Screenings and/or diagnostic testing.
  - Delivery and post-natal care.

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

3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.
7. Costs to treat sexual dysfunction and/or impotency.
8. Health care services and related 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). This exclusion does not apply to therapeutic abortion which is Pregnancy termination recommended by a doctor to save the life of the mother.

Services Provided Under Another Plan

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

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

4. Health care services during active military duty.

Transplants

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

Travel

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

Types of Care, Supportive Services, and Housing

1. Custodial Care or maintenance care.
2. Domiciliary care.
3. Private Duty Nursing and one-on-one Private Duty Nursing.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* or under *Early Intervention Services* under *Habilitative Services* in *Section 1: Covered Health Care Services*.
5. Rest cures.
6. Services of personal care aides.
7. Services in a Long-term Acute Care Facility (LTAC).
8. Independent living services.
9. Assisted living services.
10. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individuals with Disabilities Education Act.*
11. Vocational counseling, testing and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
12. Transitional Living services (including recovery residences).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses, except for treatment by an ophthalmologist after correction of Injury or illness (such as cataract or macular degeneration). This exclusion does not apply to services for which Benefits are provided as described under *Vision Correction After Surgery* in *Section 1: Covered Health Care Services*.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.

5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Over-the-counter Hearing Aids.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this Policy under *Section 1: Covered Health Care Services* and in the *Summary of Benefits and Coverage ("SBC")*.
   - Not otherwise excluded in this *Policy* 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 this *Policy* when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under this Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under this Policy ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term storage:
   - Long term storage services are not a Covered Health Care Service.
   - This includes, but is not limited to, long term storage (cryopreservation) of tissue, blood, blood products, sperm, eggs, and any other body or body parts. For example, if a member is entering the military, etc., we will not cover any long-term storage of the above.
   - Storage services related to infertility treatment usually only require short term storage which is generally covered as part of the retrieval and implantation charges for the infertility treatment.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

12. Proprietary Laboratory Analysis drug testing are not a covered service (such as U codes).
13. Blood or tissue typing for paternity testing are not a covered service.
14. Specimen Provenance testing are not a covered service.
15. Services or supplies for teaching, vocational, or self-training purposes, except as listed in the benefit plan.
16. Telephone consultations (except telemedicine) or for failure to keep a scheduled appointment.
17. Stand-by availability of a medical practitioner when no treatment is rendered.
18. Services or supplies that are provided prior to the effective date or after the termination date of this Policy.

Section 3: When Coverage Begins and Premiums

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

Who Is Eligible for Coverage?

BeWell determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

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

Eligible Persons must live within the Service Area, unless otherwise provided by BeWell.

Dependent

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

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

When Do You Enroll and When Does Coverage Begin?

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

Annual Open Enrollment Period

The annual open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by BeWell.

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

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by BeWell.

Adding New Dependents

Policyholders may enroll Dependents only as determined by BeWell.

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

NOTE. Subject to a determination of BeWell, an eligible child born to you or your spouse will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for loss due to Injury and Sickness, including loss from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Premiums

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

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

- Ryan White HIV/AIDS Program under title XXVI of the *Public Health Service Act.*
- Indian tribes, tribal organizations or urban Indian organizations.
- Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

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

If Premium payments are not made as required:

- Your coverage will end as described in *Section 4: When Coverage Ends*, under *Events Ending Your Coverage* and *Other Events Ending Your Coverage*.
- In order to enroll in a new plan after terminating for non-payment, as allowed under federal law, we may require that your re-enrollment be subject to:
  - Your payment in full of any past due premiums owed to us within the last 12 months.
  - Payment of the first month’s premium for the new plan.

Upon prior written notice, we may impose an administrative fee for credit card payments. This does not obligate us to accept credit card payments. We will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

Misstatement of Age or Tobacco Use

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

Change or Misstatement of Residence

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

Grace Period

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

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

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

If you are receiving an *Advance Payment of Tax Credit*, as allowed under *section 36B of title 26*, as provided for by the *Patient Protection and Affordable Care Act (PPACA),* you will have a three-month grace period during which you may pay your Premium and keep your coverage in force. We will pay for Covered Health Care Services during the first month of the grace period. You are responsible for paying the grace period Premium. Prior to the last day of the three-month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the first month of the grace period until all Premiums are paid for the full three-month grace period.

Adjustments to Premiums

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end this Policy and/or all similar policies for the reasons explained in this Policy.

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

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

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

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

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

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

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

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

If you believe that your coverage ended due to health status or health care requirements, race, gender, age, or sexual orientation you may appeal as described in *Summary of Health Insurance Grievance Procedure* or to the *New Mexico Office of Superintendent of Insurance* at the following address:

New Mexico Office of the Superintendent of Insurance

PO Box 1689
Santa Fe, NM 87504-1689
Phone: 1-833-415-0566

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

  - The date determined by BeWell that this Policy will terminate because the Policyholder no longer lives in the Service Area. Note that you are still eligible for coverage if you intend to reside in the Service Area, including without a fixed address, or you have entered with a job commitment or are seeking employment (whether or not currently employed).
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

Your coverage ends on the date you are no longer eligible to be a Policyholder or an Enrolled Dependent, as determined by BeWell. Please refer to *Section 8: Defined Terms* for definitions of the terms “Eligible Person,” “Policyholder,” "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

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

Other Events Ending Your Coverage

When any of the following happen, we will provide written 30 days advance notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

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

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

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

- **You Accept Reimbursement for Premium**
- You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:
  - *Ryan White HIV/AIDS Program* under *title XXVI of the Public Health Service Act.*
  - Indian tribes, tribal organizations or urban Indian organizations.
  - Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Coverage for a Disabled Dependent Child

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

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Policyholder for support.

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

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

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

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

Continuation of Coverage

Covered family members have the right to continue this policy as the named insured or through a conversion policy upon the death of the named insured or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the named insured unless coverage terminates for nonpayment of premium, nonrenewal of the policy or the expiration of the term for which the policy is issued.

Please refer to *Section 3: When Coverage Begins and Premiums* for enrollment information.

Reinstatement

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurance company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurance company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the thirtieth day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurance company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

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

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

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 one year from the time proof is otherwise required.

Required Information

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

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

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Written notice of claim must be given to the insurance company within 90 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 insurance company at the address on the back of your ID card or to any authorized agent of the insurance company, with information sufficient to identify the insured, shall be deemed notice to the insurance company.

We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished for filing proofs of loss. If such forms are not furnished within fifteen 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.

Payment of Benefits

We will pay Benefits within 30 days for a clean claim that has been submitted electronically or within 45 days of the date of receipt for a clean claim that has been submitted manually.

Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Written proof must contain all of the required information.

If a clean claim is not reimbursed within 30 days for an electronic claim or 45 days for a manual claim after receipt, we will pay interest on that amount at the rate of one and one-half times the prime lending rate for New Mexico banks during the period the claim is unpaid. Interest shall accrue, and the interest rate shall be determined, as of the 31st day or 46th day after the proof of loss was furnished.

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

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.

In the event of the Subscriber's death or incapacity, and the absence of written evidence to us of the qualification of a guardian for the Subscriber's estate, we may make any and all payments of Benefits under the Policy to the individual or institution that, in our opinion, is or was providing the Subscriber's care and support.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured’s death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Allowed Amounts

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

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

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

For Network Benefits, Allowed Amounts are based on the following:

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

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

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

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

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

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

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

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

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Policy.*

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

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The reimbursement rate as determined by state law.

- The initial payment made by us, or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

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

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

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

Section 6: Summary of Health Insurance Grievance Procedures

This is a summary of the process you must follow when you request a review of a decision by your insurer. You will be provided with detailed information and appropriate complaint forms by your insurer at each step. In addition, you can review the complete New Mexico regulations that control the process on the **Managed Health Care Bureau** page found under the **Department's** tab on the *Office of Superintendent of Insurance (OSI)* website, located at www.osi.state.nm.us. You may also request a copy from your insurer at:

P.O. Box 6111

Mail Stop CA-0197

Cypress, CA 90630

or from OSI by calling 1-505-827-4601 or toll free at 1-855-427-5674.

Prior Authorization

How does preauthorization or prior authorization for a health care service work?

When your insurer receives a request to pre-authorize payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you already had, it follows a two-step process.

Coverage: First, the insurer determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for equine therapy, then your insurer will not agree to pay for you or your child to have it even if you have a clear need for it.

Medical necessity: Next, if the insurer finds that the requested service is covered by the policy, the insurer determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the insurer. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that your insurer pay for cosmetic plastic surgery to give you a more attractive nose, your insurer may approve your first request for hand surgery but disapprove the second request due to lack of medical necessity.

Experimental or Investigational Services: Depending on the terms of your policy, your insurer might also deny authorization if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, the insurer may deny authorization. Your insurer might also deny authorization if a procedure that your provider has requested is not recognized as standard treatment for the condition being treated.

IMPORTANT: If your insurer determines that it will not certify your request for services, you may still go forward with the treatment or procedure. **However,** you may be responsible for paying the provider yourself for the services.

How long does prior authorization take?

Standard timeline prior authorization decision: The insurer must make a prior authorization decision for most benefits within 7 working days. A standard decision timeline applies to benefit certification requests that are not urgent. For example, a standard benefit certification request may involve surgical care, like routine hip replacement surgery. An insurer must make an initial decision on a standard request for an exception to an insurer's step-therapy requirements or drug formulary within 24 hours for urgent care requests and 72 hours for standard care request. A step-therapy requirement means trying a less expensive drug before "stepping up" to a more expensive option. Asking for an exception to this requirement means asking to skip the less expensive drug. A drug formulary exception request means to ask for coverage of a medication that is not on the formulary.

What if I need services in a hurry?

Urgent care situation: An **urgent care situation** occurs when a decision from the insurer is needed quickly because: **(1)** delay would jeopardize your life or health; **(2)** delay would jeopardize your ability to regain maximum

function; **(3)** the physician with knowledge of your medical condition **reasonably** requests an expedited decision; **(4)** the physician with knowledge of your medical or behavioral health condition, believes that delay would subject you to severe pain or harm that cannot be adequately managed without the requested care or treatment; or **(5)** the medical or behavioral health demands of your case require an expedited decision.

If you are facing an urgent care situation or your insurer has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and the insurer must either authorize or deny the initial request quickly. The insurer must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide you through the claims process once the emergency has passed. An insurance company is not allowed to require you to obtain prior authorization for emergency care.

When will I be notified that my initial request has been either certified or denied?

The insurance company is required to notify you on its decision about your initial request within the initial certification period timelines listed above. If the insurance company denies your certification request, it is required to tell you about your right to request an appeal.

Appeals of Denials

What types of decisions can be appealed?

You may request appeals of two different types of decisions:

Adverse determination: An adverse determination by an insurer includes any decision to deny or limit your coverage based on medical necessity. This medical necessity denial can happen pre-service, through a denial of prior authorization, or post-service, when an insurance company refuses to pay a claim. If an insurance company has adversely determined that your ongoing course of treatment that has previously been covered will no longer be covered, the insurer must notify you *before* ending or limiting that coverage. This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or nor medically necessary or appropriate.

An adverse denial may also include a decision by the plan to retroactively end your coverage or stop offering you coverage in the future based on your eligibility for coverage. For example, an insurance company's decision to stop offering you coverage because they believe you moved out of state is an adverse determination. ***You may request an appeal of any type of adverse determination.***

Administrative decision: You may also request a review if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

How to Appeal a Decision or File a Grievance

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer as well as forms and detailed instructions for requesting a review. You may submit the request for review either orally or in writing depending on the terms of your policy. The insurer provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the insurer's consumer assistance office as follows:

Medical Appeal	UnitedHealthcare Appeals & Grievances PO Box 6111 Mail Stop CA-0197 Cypress, CA 90630

	Telephone: 1-866-842-9268 Fax: 1-888-404-0949 www.myuhc.com/exchange
Prescription Drug Appeal	OptumRx c/o Appeals Coordinator PO Box 2975 Mission, KS 66201 Telephone: 1-888-403-3398 Fax: 1-877-239-4565

Always contact your insurance company first about filing an appeal or grievance and specifically ask for assistance filing an appeal or grievance.

If the insurance company is non-responsive or if you have further questions about your rights, you may contact the *New Mexico Office of the Superintendent of Insurance Managed Health Care Bureau* consumer assistance team at:

Telephone: 1-505-827-4601 or toll free at 1-855-427-5674

Address: Office of Superintendent of Insurance - MHCB

P.O. Box 1689, Santa Fe, NM 87504-1689 or

1120 Paseo de Peralta, Fourth Floor, Santa Fe, NM 87501

FAX #: (505) 827-4253, Attn: MHCB

E-mail: mhcb.grievance@osi.nm.gov

Review of an Adverse Determination

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual policy holder or a dependent who receives coverage through the policy holder. The person whose medical benefit is denied is called the "**grievant**." If you are selecting someone to act on your behalf, such as a provider, you may need to fill out a form designating that person to be your representative in the appeal.

Appealing an adverse medical necessity or coverage determination – first level review

If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director. The medical director may decide based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify the insurer that you wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that the insurer review its decision, you can ask the insurer to provide you with a list of the documents you need to provide and will provide to you all your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?

Expedited review. If a review request involves an urgent care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review. Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within 30 days after receipt of your pre-service request for review or within 60 days if you have already received the service.

The medical director denied my request - now what?

If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by the insurer or you may skip this step and ask that your request be reviewed by an *IRO* that is appointed by the *Superintendent.*

- If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with

Important: If you are covered under the NM State Healthcare Purchasing Act as a public employee, you may NOT request an IRO review if you skip the panel review.

  you or on your behalf. You may submit information that you want the panel to consider, and ask questions of the panel members. Your medical provider may also address the panel or send a written statement.

- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the *IRO,* but you will not be able to appear in person or by telephone. *OSI* can assist you in getting your information to the *IRO.*

How long do I have to make my decision?

If you wish to have your request reviewed by the insurer's panel, you must inform the insurer within **5 days** after you receive the medical director's decision. If you wish to skip the insurer's panel review and have your matter go directly to the *IRO*, you must inform *OSI* of your decision within **4 months** after you receive the medical director's decision.

What happens during a panel review?

If you request that the insurer provide a panel to review its decision, the insurer will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because the insurer felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

The insurer will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone or arrange to have someone attend with you or on your behalf. You may review all the information that the insurer will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement. The insurer's internal panel must complete its review within 30 days following your original request for an internal review of a request for pre-certification or within 60 days following your original request if you have already received the services. You will be notified within 24 hours of the panel decision or sooner if medically necessary. If you fail to provide records or other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, *but* the review process may take much longer and you will be forced to wait for a decision.

Hint: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of 30 days.

If I choose to have my request reviewed by the insurer's panel, can I still request the *IRO* review?

Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have **4 months from the date of the panel decision** to request a review by an *IRO.*

What's an *IRO* and what does it do?

An *IRO (Independent Review Organization)* is a certified organization appointed by *OSI* to review requests that have been denied by an insurer. The *IRO* employs various medical and other professionals from around the country to perform reviews. Once *OSI* selects and appoints an *IRO*, the *IRO* will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the *IRO* may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The *IRO* must assign reviewers who have no prior knowledge of the case and who

have no close association with the insurer or with you. The reviewer will consider all the information that is provided by the insurer and by you. (*OSI* can assist you in getting your information to the *IRO.*) In deciding, the reviewer may also rely on other published materials, such as clinical studies.

The *IRO* will report the final decision to you, your provider, your insurer, and to *OSI.* Your insurer must comply with the decision of the *IRO.* If the *IRO* finds that the requested services should be provided, then the insurer must provide them.

The *IRO's* fees are billed directly to the insurer – there is no charge to you for this service.

How long does an *IRO* review take?

The *IRO* must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the *IRO* has been asked to provide an expedited review regarding an urgent care matter, the *IRO* must report back within 72 hours after receiving all the information it needs to review the matter.)

Review by the Superintendent of Insurance

If you remain dissatisfied after the *IRO's* review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to *OSI,* within 20 days of the *IRO* decision, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the *Superintendent* within 30 days after the hearing is complete. The *Superintendent* will then issue a final order.

There is no charge to you for a review by the *Superintendent of Insurance* and any fees for the hearing officers are billed directly to the insurer. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?

If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within **180 days** after the date you are notified of the decision. The insurer will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

The insurer will mail a decision to you within 30 days after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have **20 days** to request that the insurer form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When the insurer receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after the insurer receives your request. You will be notified at least 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to 30 calendar days. The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the *Superintendent* to review the matter within **20 days** after you receive the written decision from the insurer. You may submit the request to

OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call *OSI* to request the forms at 1-505-827-4601 or toll free at 1-833-427-5674.

How does the external review work?

Upon receipt of your request, the *Superintendent* will request that both you and the insurer submit information for consideration. The insurer has five days to provide its information to the *Superintendent,* with a copy to you. You may also submit additional information including documents and reports for review by the *Superintendent.* The *Superintendent* will review all the information received from both you and the insurer and issue a final decision within 45 days after receipt of the complete request for external review. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

Any person who comes into contact with your personal health care records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to *OSI,* until you have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations. Call the consumer assistance number on the back of your insurance card for assistance.

Reporting requirements

Insurers are required to provide an annual report to the *Superintendent* with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the *OSI's* website.

The preceding summary has been provided by the *Office of Superintendent of Insurance.* This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

Section 7: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to this Policy and how it may affect you. We administer this Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

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

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

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

What Is Our Relationship with Providers?

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

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Providers are not required to meet any specified numbers, targeted averages, or maximum durations of patient visits.

What Is Your Relationship with Providers?

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

You are responsible for all of the following:

- Choosing your own provider. You have the choice in the selection of a birthing center or a Hospital for Hospital care or of an obstetrician/gynecologist, optometrist, Practitioner of the Healing Arts, psychologist, podiatrist, physician assistant, Certified Nurse-Midwife, Registered Lay Midwife, or Registered Nurse in Expanded Practice.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, when applicable.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

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

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs, administrative programs, and/or programs to seek care in a more cost-effective setting. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. We will notify you of the opportunity to participate in available programs and of any criteria for eligibility. Contact us at www.myuhc.com/exchange or the telephone number on your ID card if you have any questions.

As determined by us, incentives may include, but are not limited to, the following:

- A gym access or digital fitness class program.
- Gift card incentives valued at a maximum of $500 for completing certain activities throughout the year, such as having a wellness visit with your Primary Care Physician or taking other plan communication-related actions (e.g., signing up for text messages or paperless communications).

Who Interprets Benefits and Other Provisions under the Policy?

We will 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 *Policy*, the *Summary of Benefits and Coverage ("SBC")* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

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

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

This authority provision is not intended - nor is it administered - to deny Covered Persons of their lawful rights to:

- Challenge Benefit determinations as part of the internal complaint system.
- File complaints.
- Obtain independent medical exams.

This provision is designed to:

- Accommodate the rapidly changing state of medical knowledge and practice.
- Permit us to take advantage of the most current scientific and medical thinking to determine whether an experimental or unproven procedure falls within the scope of coverage.
- Decisions such as the appropriateness of medical treatment will be made by the Physician.

State and other entities (governmental agencies) also have the right to interpret the Policy.

Who Provides Administrative Services?

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

Amendments to this Policy

To the extent permitted by law, and in accordance with the legal requirements allowing us to do so (including any required notification), we have the right to change, interpret, withdraw or add Benefits or end this Policy.

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

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

- Amendments and Riders to this Policy are effective upon renewal, except as otherwise permitted by law.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

- Needed to put in place and administer the terms of this Policy.

- Needed for medical review or quality assessment.
- Required by law or regulation.

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

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

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

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

A valid authorization to disclose nonpublic personal information will be in written or electronic form separate from that used for any other purpose and is valid for no more than 24 months, unless revoked earlier.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense. We, at our own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Change of Beneficiary

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Is Workers' Compensation Affected?

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

Reimbursement - Right to Recovery

In consideration of the coverage provided by this Policy, we shall have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, if you make a recovery 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 right to reimbursement, including, but not limited to:
  - 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.

- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; and 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 Benefits we have paid on your behalf from 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 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 care 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 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.
- 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 reimbursement clause shall apply to that claim.

When Do We Receive Refunds of Overpayments?

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

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

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

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

The reductions will equal the amount of the required refund.

Is There a Limitation of Action?

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

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

What Is the Entire Policy?

This Policy, the *Summary of Benefits and Coverage ("SBC*"), the Policyholder's application, and any Riders and/or Amendments, make up the entire Policy. All statements made by the Policyholder will, in the absence of fraud, be deemed representations and not warranties and no such statements shall void the insurance or reduce Benefits unless contained in a written application for such insurance.

Provider Network

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

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

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

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

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

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

Network Transplant Providers

If you have a medical condition that we believe needs special services, we may direct you to a Network Transplant Provider for treatment. If you require a transplant or cellular gene therapy for which expertise is limited, we will help you select a provider which may be inside or outside your local geographic area.

If you are required to travel to obtain such Covered Health Care Services from a Network Transplant Provider, you will be eligible for reimbursement of certain travel and lodging expenses. Travel expenses, including tolls, parking, personal vehicle car milage (if more than 50 miles from your home), bus or train may be reimbursed up to $150 per day during the entire period of time the Covered Person is covered under the Policy.

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

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

If specific Covered Health Care Services are not available from a Network provider, you will be eligible for Network Benefits when Covered Health Care Services are received from Out-of-Network Providers with prior authorization. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an Out-of-Network Provider.

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

If you receive a Covered Health Care Service from an Out-of-Network urgent care provider, when reasonable access to a Network urgent care provider is not available, we will reimburse the Out-of-Network urgent care provider at the same level of Benefits as the Network urgent care provider. Reasonable access to a Network urgent care provider means a distance of 20 miles from the Covered Person's residence.

Section 8: Defined Terms

Air Ambulance - medical transport by helicopter or airplane.

Alcohol Dependency Treatment Center - a facility that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a Physician or meets the quality standards of the appropriate authority and which also meets the following:

- It is affiliated with a Hospital under a contractual agreement with an established system for patient referral.
- It is accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
- It meets at least the minimum standards adopted by the Substance Abuse Bureau of the Behavioral Health Services Division of the Health and Environment Department for treatment of alcoholism in regional treatment centers.

Allowed Amounts - the maximum portion of a billed charge that we will pay, including any applicable Covered Person cost sharing responsibility, for a Covered Health Care Service or item rendered by a Network provider or by an Out-of-Network Provider.

When determining Allowed Amounts, reimbursement policy guidelines are developed after review of all provider billings generally in accordance with one or more of the following methodologies:

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

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

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

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

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

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

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

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any

amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The *Summary of Benefits and Coverage ("SBC")* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities, and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

Basic Health Care Benefits - benefits for Medically Necessary services consisting of preventive care, emergency care, inpatient and outpatient Hospital and Physician care, diagnostic laboratory and diagnostic and therapeutic radiological services and does not include services for alcohol or substance use, dental or long-term rehabilitation treatment.

Behavioral Health Services - professional and ancillary services for the treatment, habilitation, prevention and identification of Mental Illnesses, substance use disorders and trauma spectrum disorders, including inpatient, detoxification, Residential Treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable.

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

Chemotherapy - charges incurred for the treatment of disease by chemical or biological antineoplastic agents or related supportive care regimens administered orally, intravenously or by injection. The chemical or biological antineoplastic agents or related supportive care regimens may be administered during a doctor's visit, home health care visit, or at an outpatient facility.

Co-insurance - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

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

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

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

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

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

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

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

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

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

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

function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - quantitative test to identify specific medications, illicit substances and metabolites with numerical results reporting the specific quantities of a substance.

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

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

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the year following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child.* We will not deny enrollment on the basis that the child: a) was born out of wedlock; b) is not claimed as a Dependent on the Policyholder's federal income tax return; or c) does not reside with the parent or in the insurer's service area.

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

Dialysis - the process in which waste products are removed from the body by diffusion from one fluid compartment to another through a semi-permeable membrane. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis.

Durable Medical Equipment (DME) - equipment or supplies prescribed by a practitioner/provider that is Medically Necessary for the treatment of an illness or accidental Injury, or to prevent the Covered Person's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of illness or accidental Injury, and includes items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

Eligible Person - a person who meets the eligibility requirements determined by BeWell. An Eligible Person must live within the Service Area.

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

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

Emergency Health Care Services - procedures, treatments or services delivered due to an Emergency.

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

Experimental or Investigational Service(s) - medical, surgical, or other health care procedures or treatments, including drugs. As used in this plan, "Experimental" or "Investigational" as related to drugs, devices and medical treatments or procedures means:

- The drug or device cannot be lawfully marketed without approval of the *U.S. Food and Drug Administration (FDA)* and approval for marketing has not been given at the time the drug or device is furnished; or

- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by State law, the drug or device is used for a purpose that is not approved by the *FDA*; or
- For the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in State law; the written protocol or protocols used by the treatment facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, "Experimental" or "Investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

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

Functional or Physical Impairment - a Functional or Physical or Physiological Impairment which causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas:

- physical and motor tasks;
- independent movement;
- performing basic life functions.

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

Habilitative Services - services that help a person learn, keep, or improve skills and functional abilities that they may not be developing normally.

Hearing Aid(s) - Hearing Aids are sound-amplifying devices designed to aid people who have a hearing impairment. Most Hearing Aids share several similar electronic components, and technology used for amplification may be analog or digital. (Semi-implantable electromagnetic Hearing Aids and bone-anchored Hearing Aids are classified by the *U.S. Food and Drug Administration (FDA)* as Hearing Aids. Some non-wearable hearing devices are described as hearing devices or hearing systems. Because their function is to bring sound more effectively into the ear of a person with hearing loss, for the purposes of this Policy, they are Hearing Aids).

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

Home Health Care Services - services provided to a Covered Person confined to the home due to physical illness. Home Health Care Services and home intravenous services and supplies will be provided by a Home Health Agency at a Covered Person's home when prescribed by the Covered Person's practitioner/provider.

Hospice Care - an integrated, structured, multi-disciplinary program of palliative care for covered members facing the last six months of life due to a Terminal Illness.

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

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

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

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

Independent Freestanding Emergency Department - a health care facility that:

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

Infusion Therapy - means treatment by placing therapeutic agents into the vein and parenteral administration of medications and nutrients.

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

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

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

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

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA).*

Intensive Outpatient Program - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

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

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

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.

Maintenance Program - A program with the goals to maintain the functional status or to prevent decline in function.

Medically Necessary - health care services, that are all of the following as determined by us or our designee in consultation with your health care provider.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

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

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

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

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Delegate - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association.* The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Morbid Obesity Surgery - procedures that are performed to treat comorbid conditions associated with morbid obesity.

Necessary Medical Supplies - medical supplies that are used in the home with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

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

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

Network Area - the Service Area, supplemented by any additional providers we include as Network Area providers. Contact us at www.myuhc.com/exchange or the telephone number on your ID card for additional information on the Network Area.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Summary of Benefits and Coverage ("SBC")* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Network Transplant Provider - a provider and/or facility that has entered into an agreement with us, or with an organization contracting on our behalf to deliver transplant services. Network Transplant Providers may or may not be located within your geographic area. If travel is necessary to obtain such Covered Health Care Services from a Network Transplant Provider, you may be eligible for reimbursement of certain travel expenses. A Hospital or Physician that is in the Network for medical services may not be Network Transplant Provider. To receive Network Benefits for transplantation services, it is important that we, in consultation with your provider, assist you with locating a Network Transplant Provider for care.

You can find out if your provider is a Network Transplant Provider by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Summary of Benefits and Coverage ("SBC")* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Network Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law that does not have a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, obstetrician-gynecologist, physician's assistant, Certified Nurse Midwife, Registered Lay Midwife or Registered Nurse in Expanded Practice, Certified Nurse Practitioner, independent social worker, woman's health care provider, Practitioner of the Healing Arts or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician.

Out-of-Network Provider - when used to describe a provider of health care services, this means a provider that does not have a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Summary of Benefits and Coverage ("SBC")* will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment/High Intensity Outpatient - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, obstetrician-gynecologist, physician's assistant, Certified Nurse Midwife, Registered Lay Midwife or Registered Nurse in Expanded Practice, Certified Nurse Practitioner, independent social worker, woman's health care provider, Practitioner of the Healing Arts, *Doctor of Oriental Medicine* or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician.

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

- This Policy.
- *Summary of Benefits and Coverage ("SBC").*
- Policyholder *Application*.
- Riders.
- Amendments.

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

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

Practitioner of the Healing Arts - any person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition pursuant to:

- *The Chiropractic Physician Practice Act.*
- *The Dental Health Care Act.*
- *The Medical Practice Act.*
- *Chapter 61, Article 10 NMSA 1978.*
- The *Acupuncture and Oriental Medicine Practice Act.*

Pregnancy - includes all of the following:

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

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

Presumptive Drug Test - qualitative test to determine the presence or absence of drugs or a drug class with results indicating a negative or positive result.

Primary Care Physician - a Physician , geriatrician, internist, physician assistant, or nurse practitioner who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine, who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to Covered Persons.

Private Duty Nursing - A provision of continuous Skilled Care from Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) in an individual's residence by a Home Health Agency, under the direction of the patient's Physician.

Provider - A licensed provider who is contracted to provide medical services to Covered Persons (as defined within the provider contract). The provider may be a Hospital, pharmacy, other facility or a Physician or health care professional who has contractually accepted the terms and conditions as set forth.

Qualified Health Plan Issuer - a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from BeWell.

Recognized Amount - the amount which Co-payment, Co-Insurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Ac*t. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Reconstructive Surgery - means the following:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly.
- Surgery and follow-up treatment to correct a physical functional disorder following an Injury or incidental to any surgery.
- Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

Rehabilitation - health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote physiologic monitoring must be ordered by a licensed physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment - treatment in a Residential Treatment Center, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Medication provision/assistance.
  - Counseling.
  - Referral and orientation to specialized community resources.

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

Residential Treatment Center - a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a Residential Treatment program, and has staff available twenty-four hours a day.

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

Secretary - as that term is applied in the *No Surprises Act* of the C*onsolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency.

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.

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

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.

Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. This does not include a facility primarily for rest, the aged, treatment of substance-related and addictive disorders services, or for care of behavioral health disorders.

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

Specialty Dispensing Entity - a pharmacy, provider, or facility 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. Not all Network pharmacies, providers, or facilities are Specialty Dispensing Entities.

Sub-Acute Facility - means a facility that provides intermediate care on short-term or long-term basis.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Temporomandibular Joint Syndrome (TMJ) - Temporomandibular joint and muscle disorders are a collective group of conditions and symptoms characterized by pain and dysfunction to the temporomandibular joint and/or surrounding muscles that control jaw movement. Symptoms often include pain or tenderness to the temporomandibular joint, ear, neck, back, or shoulder pain, limited jaw mobility, or audible sounds with jaw movement.

Terminal Illness - in the context of hospice means a life expectancy, certified by two Physicians, of six months or less.

Tertiary Care Facility - a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria*, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery; or
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery. Please note: these living arrangements are also known as supportive housing (including recovery residences).

Unproven Service(s) - services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical or behavioral health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or observational studies in the prevailing published peer-reviewed medical literature. These include:

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s), including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish

that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care - Medically Necessary health care services provided in urgent situations for unforeseen conditions due to illness or Injury that are not life-threatening but require prompt medical attention.

Urgent Care Center - a facility operated to provide health care services in emergencies or after hours, or for unforeseen conditions due to illness or Injury that are not life-threatening but require prompt medical attention.

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

Section 9: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

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

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

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

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

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

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

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

B. 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) Unless specified otherwise, the plan determined to be primary by mutual consent of the plans, pays first.

   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) The plan of the parent decreed by a court of law to have responsibility for medical coverage pays first.

      (2) When a court decree or order requires both parents to maintain medical coverage, the plan determined to be primary by mutual consent of the parties pays first.

      (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 non-Custodial Parent.

         (c) The Plan covering the Custodial Parent's spouse.

         (d) The Plan covering the non-Custodial Parent's spouse.

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

   d) 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.

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.

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Medicaid

If a person is covered by *Medicaid*, any overlapping benefits they receive from health insurance or reimbursed payments under *Third Party Liability* rules shall be paid to the Health Service Department or the appropriate state agency.

Section 10: Outpatient Prescription Drugs

This section of the Policy provides Network Benefits for Prescription Drug Products.

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

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

NOTE: The Coordination of Benefits provision in the Policy in *Section 9: Coordination of Benefits* applies to Prescription Drug Products covered through this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in this Policy.

Introduction

Coverage Policies and Guidelines

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

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

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These reviews and changes may happen up to monthly, but not within one hundred twenty days of any previous change to coverage for that Prescription Drug Product. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. In the event that a change in Prescription Drug Product negatively impacts you, we will notify you no less than 60 days prior to the change. Please contact us at www.myuhc.com/exchange or the telephone number on your ID card for the most up-to-date tier placement.

We, as a plan that provides prescription drug Benefits categorized or tiered for purposes of cost-sharing through deductibles or Co-insurance obligations, will not make any of the following changes to coverage for a Prescription Drug Product within one hundred twenty days of any previous change to coverage for that Prescription Drug Product unless a generic version of the Prescription Drug Product is available. You will be notified sixty days in advance of any of the following changes to the PDL:

- Reclassify a drug to a higher tier of the Prescription Drug List;
- Reclassify a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the Prescription Drug List;
- Increase the cost-sharing, Co-payment, deductible or Co-insurance charges for a drug;
- Remove a drug from the Prescription Drug List;
- Establish a prior authorization requirement;
- Impose or modify a drug’s quantity limit; or
- Impose a step-therapy restriction.

We may immediately and without prior notice remove a drug from the Prescription Drug List if the drug:

- Is deemed unsafe by the *U.S. Food and Drug Administration (FDA)*; or
- Has been removed from the market for any reason.

We will provide to each affected Covered Person the following information in plain language regarding prescription drug Benefits:

- Notice that we use one or more Prescription Drug Lists;
- An explanation of what the Prescription Drug List is;
- A statement regarding the method we use to determine the prescription drugs to be included in or excluded from a Prescription Drug List; and
- A statement of how often we review the contents of each Prescription Drug List.

When considering a Prescription Drug Product for tier placement, the IPMC reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: Tier status for a Prescription Drug Product may be determined by accessing your Benefits for Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. The tier to which a Prescription Drug Product is assigned may change as detailed in the Policy.

Prescription Drug Products that are considered to be PPACA Zero Cost Share Preventive Care Medications will be provided at $0 cost share for Covered Persons.

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim.* When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Specialty Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Specialty Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Specialty Pharmacy, you may not have coverage.

When Do We Limit Selection of Pharmacies?

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

Discounts, Incentives and Other Communications

From time to time, we may make access available to discounts or incentive programs. Incentive programs may be available only to targeted populations and may include other incentives. These discount and incentive programs are not insurance and are not an insurance benefit or promise in the Policy. Your access to these programs is provided by us separately or independently from the Policy, and may be discontinued at any time. There is no additional charge for you to access these discount and incentive programs. These programs may be offered or administered directly by us or through a third party vendor. If we receive any funds from a third party vendor in conjunction with making the discount or incentive programs available to you, we will use those funds to offset our costs of providing you access to the programs.

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

Special Programs

We may have certain programs in which you may receive an enhanced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Co-insurance and/or any applicable deductible or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Summary of Benefits and Coverage ("SBC")* for applicable Co-payments, Co-insurance and/or any applicable deductible requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

Benefits are available for Preferred brand drugs, Non-preferred brand drugs, and 90-day supply of mail order medications, as appropriate, from retail or mail order pharmacies.

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

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore, your Co-payment and/or Co-insurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the *Summary of Benefits and Coverage ("SBC")*. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

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

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

Please see *Defined Terms for Outpatient Prescription Drugs* for a full description of Specialty Prescription Drug Products.

The *Summary of Benefits and Coverage ("SBC")* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drug Products from a Retail Network Pharmacy

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

The *Summary of Benefits and Coverage ("SBC")* will tell you how retail Network Pharmacy supply limits apply.

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

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The *Summary of Benefits and Coverage ("SBC")* will tell you how mail order Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com/exchange or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

PPACA and Preventive Care Medications

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), certain preventive medications are available to you at no cost, both prescription and over-the-counter (OTC). These are called PPACA Zero Cost

Share Preventive Care Medications. These preventive medications are covered at no cost to you, without charging a Co-payment, Co-insurance, or deductible when:

- Prescribed by a Physician;
- Your age and/or condition is appropriate for the recommended preventive medication;
- The medication is filled at a Network Pharmacy.

Contact us at www.myuhc.com/exchange or call the number on your ID card to find out if a medication is a PPACA Zero Cost Share Preventive Care Medication.

If your health care provider determines you need a medication that is not on the PPACA Zero Cost Share Preventive Care Medication list, they can let us know your medication is Medically Necessary and provide information about your diagnosis and medication history. If you are using your medication for an appropriate condition and it is approved, it will be covered at no cost to you. If you are using it to treat another medical condition, a cost share may apply.

List of Zero Cost Share Medications

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

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

Refill Synchronization

We shall allow you to fill or refill a prescription for less than a thirty-day supply and apply a prorated daily copayment or coinsurance for the fill or refill, if:

- The prescriber determines the fill or refill to be in your best interest;
- You request or agree to receive less than a thirty-day supply of the prescription drug; and
- The reduced fill or refill is made for the purpose of synchronizing the insured's prescription drug fills.

You may access information on these procedures through the Internet at www.myuhc.com/exchange or by calling 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 are provided under *Pharmaceutical Products – Outpatient* in *Section 1: Covered Health Care Services*, regardless of tier placement. This includes anticancer medications used to kill or slow the growth of cancerous cells.

Benefits for Behavioral Health Services Zero Cost Share Medications

Benefits will be provided for prescription drugs indicated for Behavioral Health Services treatment at no charge for Generic Drugs or Brand-name Drugs when a generic equivalent is not available. Zero cost share applies to behavioral health Prescription Drug Products obtained at a Network Pharmacy only.

Pharmacotherapy for Tobacco Cessation Treatment

Benefits for Prescription Drug Products are available for pharmacotherapy when prescribed by a Physician for tobacco cessation treatment and are limited to:

- Two 90-day courses of pharmacotherapy per Covered Person per calendar year.
- Initiation of any course of pharmacotherapy will be considered an entire course of pharmacotherapy, even if a Covered Person discontinues or fails to complete the course.

Over-the-counter PPACA Zero Cost Share Preventive Care Medications for tobacco cessation covered as part of the two 90-day courses of pharmacotherapy per Covered Person include: Nicotine replacement gum, nicotine replacement lozenge, nicotine replacement patch. Prescription tobacco cessation medications include bupropion sustained-release (generic Zyban) tablet, Nicotrol Inhaler, Nicotrol Nasal Spray, and varenicline tartrate (generic Chantix) tablet. Please note, this list is subject to change.

For the purposes of this Policy, "pharmacotherapy" means the use of first-line drugs, approved by the U.S. Food and Drug Administration (FDA) and available by prescription only, to assist in the cessation of tobacco use or smoking. Benefits for pharmacotherapy for tobacco cessation treatment are subject to all applicable requirements of this Policy.

Contraceptive Coverage

You are entitled to receive certain covered contraception services and supplies without cost sharing and without prior approval from us. This means that you do not have to make a Co-payment, Co-insurance, satisfy a deductible or pay out-of-pocket for any part of contraception Benefits if you receive them from a Network provider.

You may owe cost sharing if you receive a Brand-name contraceptive when at least one generic or a therapeutic equivalent is available.

Note: Additional contraceptive Benefits are available under *Preventive Care Services* in *Section 1: Covered Health Care Services.*

Covered Contraceptive Methods

- Oral Contraceptives (The Pill) (Combined Pill)
- Oral Contraceptives (Extended/Continuous Use)
- Oral Contraceptives (Mini Pill – Progestin Only)
- Patch
- Vaginal Contraceptive Ring
- Diaphragm with Spermicide
- Sponge with Spermicide
- Cervical Cap with Spermicide
- Male Condom
- Female Condom
- Spermicide
- Emergency Contraceptive – “Plan B”
- Emergency Contraceptive – “Ella”

Six Month Dispensing

You are entitled to receive up to a six-month supply of contraceptives, if prescribed and self-administered, when dispensed at one time by your pharmacy. If you need to change your contraceptive method before the six-month supply runs out, you may do so without cost-sharing. You will not owe cost sharing for any related contraceptive counseling or side-effects management.

Brand Name Drugs or Devices

Your plan may exclude or apply cost sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Please see the table of contraceptive categories above. Ask your provider about a possible equivalent.

Non-Covered Contraceptives

If your provider determines that a non-covered contraceptive is Medically Necessary, your provider may ask us to cover that contraceptive without cost-sharing. If we deny the request, you or your provider can submit a grievance

to contest that denial. If your health care provider determines that the use of a non-covered contraceptive is Medically Necessary, the health care provider's determination will be final.

Male Condoms

This plan covers male condoms. No prescription or cost sharing is required for coverage of male condoms. Please see the section below on *Coverage for Contraception Where a Prescription Is Not Required* for instructions on reimbursement for condoms.

Sexually Transmitted Infections

Your plan covers, and no cost sharing applies to, contraception methods that are prescribed for the prevention and treatment of sexually transmitted infections.

Coverage for Contraception Where a Prescription Is Not Required

Your plan covers contraception with no cost sharing even when a prescription is not required. Contraceptive methods such as condoms or Plan B may fall into this category. You will not have to pay upfront for contraceptives that do not require a prescription when obtained through a Network pharmacy. For all other purchases, you may submit a request for reimbursement as follows:

- Within 90 days of the date of purchase of the contraceptive method,
- Provide the receipt with the item name and amount, your name, address, plan ID number, to the following:

  OptumRx Claims Department

  PO Box 650334

  Dallas, TX 75265-0334

  Or,
- Provide the receipt with the reimbursement form available at www.myuhc.com/exchange, to the following:

  OptumRx Claims Department

  PO Box 650334

  Dallas, TX 75265-0334

If you submit your complete request for reimbursement electronically or by fax, we will reimburse you within 30 days of receiving the request. If you submit your complete request for reimbursement by U.S. mail, we will reimburse within 45 days. Failure to submit a complete request may lead to delays in reimbursement.

Availability of Out-of-Network Coverage

Under your plan, use of an Out-of-Network Provider to prescribe or dispense contraceptive coverage is not a covered Benefit.

Do Prior Authorization Requirements Apply?

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

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

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

The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change, but not less than one hundred twenty days of any previous change to coverage for that Prescription Drug Product, unless a generic version of the prescription drug is available. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by accessing your Prescription Drug List at

https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists/individual-exchange or by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Uniform prior authorization forms can be found online at https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/pa-requirements/commercial/NM-Commercial-Prior-Author-Form.pdf or requested by calling us at the telephone number on your ID card. Once the uniform prior authorization form has been received, a response will be sent within three business days or be deemed approved.

If your Physician or your pharmacist is not able to obtain prior authorization from us before the Prescription Drug Product is dispensed, you may seek reimbursement after you receive the Prescription Drug Product. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

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

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

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

Prior authorization requirements do not apply to medication approved by the *U.S. Food and Drug Administration (FDA)* that is prescribed for the treatment of an autoimmune disorder, cancer, or a substance use disorder, pursuant to a medical necessity determination, except in cases in which a biosimilar, interchangeable biologic or generic version is available.

Does Step Therapy Apply?

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

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

If your prescribing practitioner determines that a particular step therapy drug is not appropriate, the provider may submit a medical rationale as to why a particular prescription drug should be substituted. We will work with your prescribing practitioner in making an exception and authorizing the Medically Necessary substituted drug.

An exception to step therapy requirements may be requested in the following circumstances:

- If the step therapy drug is contraindicated or will likely cause an adverse reaction or may cause you physical or mental harm;
- If the step therapy drug is expected to be ineffective based on your known clinical characteristics and the known characteristics of the prescription drug regimen;
- While covered under this Policy or your previous health coverage, you have tried the step therapy drug or another prescription drug in the same pharmacologic class or with the same mechanism of action as the step therapy drug and that drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or
- The step therapy protocol is not in your best interest, based on clinical appropriateness, because your use of the prescription drug is expected to:
    - Cause a significant barrier to your adherence to, or compliance with, your plan of care;
    - Worsen a comorbid condition;
    - Decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

If an exception to step therapy requirements is granted, coverage of the prescription drug that is the subject of the exception request will be authorized for no less than the duration of the therapeutic effect of the drug.

Step therapy requirements do not apply to contraceptives. In addition, step therapy requirements do not apply to medication approved by the *U.S. Food and Drug Administration (FDA)* that is prescribed for the treatment of an autoimmune disorder, cancer, or a substance use disorder, pursuant to a medical necessity determination, except in cases in which a biosimilar, interchangeable biologic or generic version is available.

Your Right to Request an Exception When a Medication is Not Listed on the Prescription Drug List (PDL)

When a Prescription Drug Product is not listed on the PDL, you, your designee, or your prescribing Physician (or other prescriber) may request an exception for the Prescription Drug Product not listed on the PDL to be covered as if it were included in the PDL. Review of an exception request takes into consideration the type of Prescription Drug Product, how it is administered, and the associated Medically Necessary services.

The treatment for which the Prescription Drug Product not listed on the PDL is prescribed must be a Covered Health Care Service. In addition, your prescribing Physician (or other prescriber) in consultation with us must determine that:

- The Prescription Drug Product on the PDL has been, or is reasonably expected to be, less effective for you; or
- The Prescription Drug Product on the PDL has caused, or is reasonably expected to cause, you to experience adverse reactions.

Standard Exception Request

To request an exception, you, your designee, or your prescribing Physician (or other prescriber) may contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the second highest tier. For example, if you have a 5-tier plan, then the 4th tier would be considered the second highest tier.

Expedited Exception Request

Based on exigent circumstances, you, your designee or your prescribing physician (or other prescriber) may request an expedited review. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. We will make a coverage determination on an expedited review request based on exigent circumstances and notify you, your designee and the prescribing physician (or other prescriber, as appropriate) of our coverage determination no later than 24 hours following receipt of the request. If we grant an exception based on exigent circumstances, we will provide coverage of the non-formulary drug for the duration of the exigency.

External Exception Request Review

If we deny a request for a standard exception or an expedited exception, you, your designee or your prescribing Physician (or other prescriber) may request that the original exception request and subsequent denial of such request be reviewed by an *Independent Review Organization (IRO)*. We will make a determination on the external exception request and the *IRO* will notify you, your designee and your prescribing physician (or other prescriber, as appropriate) of the coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception request, and no later than 24 hours following receipt of the request if the original request was an expedited exception. If we grant an external exception review of a standard exception request, we will provide coverage of the non-formulary drug for the duration of the prescription. If we grant an external exception of an expedited exception request, we will provide coverage of the non-formulary drug for the duration of the exigency.

What Do You Pay?

You are responsible for paying the Annual Deductible stated in the *Summary of Benefits and Coverage ("SBC")* which is attached to your Policy before Benefits for Prescription Drug Products under this Policy are available to you unless otherwise allowed under your Policy.

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the *Summary of Benefits and Coverage ("SBC")* table. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

The Co-payment amount or Co-insurance percentage you pay for a Prescription Drug Product will not exceed the Usual and Customary Charge of the Prescription Drug Product.

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

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

We will not produce a health benefits plan for sale or pharmacy benefits services for contract without prior disclosure to the purchaser of the plan or services of the option to contract for pharmaceutical drug cost-sharing protections. When calculating your cost-sharing obligation for covered prescription drugs, we shall credit you for discounts provided or payments made by manufacturers at the time of the prescription drug claim, and the amount will accumulate toward your Out-of-Pocket Limit.

Payment Information

NOTE: When Covered Health Care Services are provided by an Indian Health Service provider, your cost share may be reduced.

Payment Term And Description

Co-payment

Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.

Co-insurance

Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.

You may obtain up to a 30-day supply of insulin products listed on the Prescription Drug List at a Network Pharmacy at $0 cost to you. The Co-payment or Co-insurance you pay for any covered prescription insulin drug will not exceed $25 for a 30-day supply.

For Prescription Drug Products at a Retail Network Pharmacy, you are responsible for paying the lowest of the following:

- The applicable Co-payment and/or Co-insurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:

- The applicable Co-payment and/or Co-insurance.
- The Prescription Drug Charge for that Prescription Drug Product.

You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

Outpatient Prescription Drugs Exclusions

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

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

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay. These drugs are covered under *Hospital – Inpatient Stay* in *Section 1: Covered Health Care Services*.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not include a Prescription Drug Product provided to a patient during a cancer clinical trial if the drug has been approved by the *U.S. Food and Drug Administration (FDA),* whether or not the *FDA* has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss, except as required for the treatment of obesity and morbid obesity.
10. A Pharmaceutical Product for which Benefits are provided in your Policy. This includes certain forms of vaccines/immunizations. This exclusion does not apply to certain injectable drugs used for contraception.
11. Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Policy. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride to prevent dental cavities in children.
13. Certain 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 Care Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

17. Prescription Drug Products when prescribed to treat infertility except for the diagnosis and treatment of any underlying cause of infertility as described under *Physician's Office Services – Sickness and Injury* in *Section 1: Covered Health Care Services*.

18. Prescription Drug Products not placed on a tier of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing 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 alternative. For information about this process, call the telephone number on your ID card.

19. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 5.)

20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to select over-the-counter drugs used for tobacco cessation.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our IPMC.

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

23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. For enteral nutrition, see *Enteral Nutrition* in *Section 1: Covered Health Care Services.*

24. 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 monthly, but no more than one hundred twenty days of any previous change to coverage for that Prescription Drug Product. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. 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 monthly, but no more than one hundred twenty days of any previous change to coverage for that Prescription Drug Product. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. 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 monthly, but no more than one hundred twenty days of any previous change to coverage for that Prescription Drug Product. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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

28. A Prescription Drug Product with either:

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

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

- It is highly similar to a reference product (a biological Prescription Drug Product) and
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
- Such determinations may be made up to monthly, but no more than one hundred twenty days of any previous change to coverage for that Prescription Drug Product. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

29. Diagnostic kits and products, including associated services.
30. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
31. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
32. Drugs to treat sexual dysfunction and/or impotency.

Defined Terms for Outpatient Prescription Drugs

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

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

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

Individual and Family Plan Pharmacy Management Committee (IPMC) - the committee that we designate for placing Prescription Drug Products into specific tiers.

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

Network Pharmacy - a pharmacy that has:

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

A Network Pharmacy may be a:

- Retail Network Pharmacy.
- Specialty Network Pharmacy.
- Mail Order Network Pharmacy.

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

- The date it is placed on a tier by our IPMC.
- December 31st of the following calendar year.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance or 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*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

Prescription Drug List (PDL) - a list of Prescription Drug Products that are covered by your Policy. This list places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*

(FDA). This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips;
  - certain insulin pumps;
  - certain continuous glucose monitors;
  - lancets and lancet devices;
  - glucose meters, including those for individuals with disabilities, including the legally blind;
  - injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind;
  - glucagon emergency kits; and
  - prescriptive oral agents for controlling blood sugar.

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

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

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

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

Section 11: Pediatric Dental Care Services

How Do You Use This Document?

This section of the Policy provides Benefits for Covered Dental Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

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

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

How do you Access Pediatric Dental Care Services?

Network Benefits

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

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

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

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

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

What Are Covered Dental Care Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Care Services are provided.

Payment Information

Benefits:

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

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

Annual Deductible

Benefits for Pediatric Dental Care Services provided under this section are subject to the Annual Deductible stated in the *Summary of Benefits and Coverage ("SBC")*.

Out-of-Pocket Limit - any amount you pay in Coinsurance for Pediatric Dental Care Services under this section applies to the Out-of-Pocket Limit stated in the *Summary of Benefits and Coverage ("SBC")*.

Benefits for Pediatric Dental Care Services

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

A. Necessary.

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

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

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

Benefits

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

Pediatric Dental Exclusions

Except as may be specifically provided in this section under the heading *Benefits for Pediatric Dental Care Services*, Benefits are not provided under this section for the following:

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

replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

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

Defined Terms for Pediatric Dental Care Services

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

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

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

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

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

Necessary - Dental Care Services and supplies under this section which are determined by us in consultation with your provider through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.

- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

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

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

Benefit Descriptions and Frequency Limitations

Diagnostic Services

Evaluations (Checkup Exams) - Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.

Periodic oral evaluation.

Limited oral evaluation - problem focused.

Teledentistry - synchronous - real time encounter.

Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review.

Comprehensive oral evaluation.

Comprehensive periodontal evaluation.

The following service is not subject to a frequency limit.

Detailed and extensive oral evaluation - problem focused.

Intraoral Radiographs (X-ray) - Limited to 2 series of films per 12 months.

Complete series (including bitewings).

Intraoral - complete series of radiographic images - image capture only.

The following services are not subject to a frequency limit.

Intraoral - periapical first film.

Intraoral - periapical - each additional film.

Intraoral - occlusal film.

Intraoral - occlusal radiographic image - image capture only.

Intraoral - periapical radiographic image - image capture only.

Any combination of the following services is limited to 2 series of films per 12 months.

Bitewings - single film.

Bitewings - two films.

Bitewings - four films.

Vertical bitewings.

Intraoral - bitewing radiographic image - image capture only.

Limited to 1 time per 36 months.

Panoramic radiograph image.

Panoramic radiographic image - image capture only.

2-D Cephalometric radiographic image - image capture only.

3-D Photographic image - image capture only.

The following service is limited to two images per calendar year.

Extra-oral posterior dental radiographic image - image capture only.

The following services are not subject to a frequency limit.

Cephalometric X-ray.

Oral/Facial photographic images.

Interpretation of diagnostic image.

Diagnostic casts.

2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.

Preventive Services

Dental Prophylaxis (Cleanings) - Limited to two times every 12 months.

Prophylaxis - adult.

Prophylaxis - child.

Fluoride Treatments - Limited to two times every 12 months.

Fluoride.

Sealants (Protective Coating) - Limited to once per first or second permanent molar every 36 months.

Sealant - per tooth - unrestored permanent molar.

Preventive resin restorations in moderate to high caries risk patient - permanent tooth.

Space Maintainers (Spacers) - Not subject to a frequency limit.

Space maintainer - fixed, unilateral - per quadrant.

Space maintainer - fixed - bilateral maxillary.

Space maintainer - fixed - bilateral mandibular.

Space maintainer - removable, unilateral - per quadrant.

Space maintainer - removable - bilateral maxillary.

Space maintainer - removable - bilateral mandibular.

Re-cement or re-bond bilateral space maintainer - maxillary.

Re-cement or re-bond bilateral space maintainer - mandibular.

Re-cement or re-bond unilateral space maintainer - per quadrant.

Removal of fixed unilateral space maintainer - per quadrant.

Removal of fixed bilateral space maintainer - maxillary.

Removal of fixed bilateral space maintainer - mandibular.

Distal shoe space maintainer - fixed - unilateral - per quadrant.

Minor Restorative Services

Amalgam Restorations (Silver Fillings) - Not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.

Amalgams - one surface, primary or permanent.

Amalgams - two surfaces, primary or permanent.

Amalgams - three surfaces, primary or permanent.

Amalgams - four or more surfaces, primary or permanent.

Composite Resin Restorations (Tooth Colored Fillings) - Not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.

Resin-based composite - one surface, anterior.

Resin-based composite - two surfaces, anterior.

Resin-based composite - three surfaces, anterior.

Resin-based composite - four or more surfaces or involving incised angle, anterior.

Crowns/Inlays/Onlays

The following services are subject to a limit of one time every 60 months.

Onlay - metallic - two surfaces.

Onlay - metallic - three surfaces.

Onlay - metallic - four surfaces.

Crown - porcelain/ceramic substrate.

Crown - porcelain fused to high noble metal.

Crown - porcelain fused to predominately base metal.

Crown - porcelain fused to noble metal.

Crown - porcelain fused to titanium and titanium alloys.

Crown - 3/4 cast high noble metal.

Crown - 3/4 cast predominately base metal.

Crown - 3/4 porcelain/ceramic.

Crown - full cast high noble metal.

Crown - full cast predominately base metal.

Crown - full cast noble metal.

Crown - titanium and titanium alloys.

Prefabricated stainless steel crown - primary tooth.

Prefabricated stainless steel crown - permanent tooth.

The following services are not subject to a frequency limit.

Inlay - metallic - one surface.

Inlay - metallic - two surfaces.

Inlay - metallic - three surfaces.

Re-cement inlay.

Re-cement crown.

Protective restoration.

The following service is limited to one time per tooth every 60 months.

Prefabricated porcelain crown - primary.

Core buildup, including any pins.

Pin retention - per tooth, in addition to crown.

The following services are not subject to a frequency limit.

Prefabricated post and core in addition to crown.

Crown repair necessitated by restorative material failure.

Inlay repair.

Onlay repair.

Veneer repair.

The following service is limited to one time per tooth every 36 months.

Resin infiltration/smooth surface.

Endodontics

The following services are not subject to a frequency limit.

Therapeutic pulpotomy (excluding final restoration).

Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.

Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration).

Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).

Anterior root canal (excluding final restoration).

Bicuspid root canal (excluding final restoration).

Molar root canal (excluding final restoration).

Retreatment of previous root canal therapy - anterior.

Retreatment of previous root canal therapy - bicuspid.

Retreatment of previous root canal therapy - molar.

Apexification/recalcification - initial visit.

Apexification/recalcification - interim medication replacement.

Apexification/recalcification - final visit.

Pulpal regeneration.

Apicoectomy/periradicular - anterior.

Apicoectomy/periradicular - bicuspid.

Apicoectomy/periradicular - molar.

Apicoectomy/periradicular - each additional root.

Surgical repair of root resorption - anterior.

Surgical repair of root resorption - premolar.

Surgical repair of root resorption - molar.

Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.

Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.

Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

Root amputation - per root.

Hemisection (including any root removal), not including root canal therapy.

Periodontics

The following services are limited to a frequency of one every 36 months.

Gingivectomy or gingivoplasty - four or more teeth.

Gingivectomy or gingivoplasty - one to three teeth.

Gingivectomy or gingivoplasty - with restorative procedures, per tooth.

Gingival flap procedure , four or more teeth.

Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.

Osseous surgery.

Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant.

Bone replacement graft - first site in quadrant.

The following services are not subject to a frequency limit.

Clinical crown lengthening - hard tissue.

Pedicle soft tissue graft procedure.

Free soft tissue graft procedure.

Subepithelial connective tissue graft procedures, per tooth.

Soft tissue allograft.

Free soft tissue graft - first tooth.

Free soft tissue graft - additional teeth.

The following services are limited to one time per quadrant every 24 months.

Periodontal scaling and root planing - four or more teeth per quadrant.

Periodontal scaling and root planing - one to three teeth per quadrant.

Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.

The following service is limited to a frequency to one per lifetime.

Full mouth debridement to enable comprehensive evaluation and diagnosis.

The following service is limited to four times every 12 months in combination with prophylaxis.

Periodontal maintenance.

Removable Dentures

The following services are limited to a frequency of one every 60 months.

Complete denture - maxillary.

Complete denture - mandibular.

Immediate denture - maxillary.

Immediate denture - mandibular.

Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth).

Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth).

Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).

Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).

Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.

Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.

Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant.

Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.

The following services are not subject to a frequency limit.

Adjust complete denture - maxillary.

Adjust complete denture - mandibular.

Adjust partial denture - maxillary.

Adjust partial denture - mandibular.

Repair broken complete denture base.

Repair broken complete denture base - mandibular.

Repair broken complete denture base - maxillary.

Replace missing or broken teeth - complete denture.

Repair resin denture base.

Repair resin partial denture base - mandibular.

Repair resin partial denture base - maxillary.

Repair cast framework.

Repair cast partial framework - mandibular.

Repair cast partial framework - maxillary.

Repair or replace broken retentive/clasping materials - per tooth.

Replace broken teeth - per tooth.

Add tooth to existing partial denture.

Add clasp to existing partial denture.

The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months.

Rebase complete maxillary denture.

Rebase maxillary partial denture.

Rebase mandibular partial denture.

Reline complete maxillary denture (direct).

Reline complete mandibular denture (direct).

Reline maxillary partial denture (direct).

Reline mandibular partial denture (direct).

Reline complete maxillary denture (indirect).

Reline complete mandibular denture (indirect).

Reline maxillary partial denture (indirect).

Reline mandibular partial denture (indirect).

Reline mandibular partial denture (laboratory).

Add metal substructure to acrylic full denture (per arch).

The following services are not subject to a frequency limit.

Tissue conditioning (maxillary).

Tissue conditioning (mandibular).

Bridges (Fixed partial dentures)

The following services are not subject to a frequency limit.

Pontic - cast high noble metal.

Pontic - cast predominately base metal.

Pontic - cast noble metal.

Pontic - titanium and titanium alloys.

Pontic - porcelain fused to high noble metal.

Pontic - porcelain fused to predominately base metal.

Pontic - porcelain fused to noble metal.

Pontic - porcelain fused to titanium and titanium alloys.

Pontic - porcelain/ceramic.

Retainer - cast metal for resin bonded fixed prosthesis.

Retainer - porcelain/ceramic for resin bonded fixed prosthesis.

Inlay/onlay - porcelain/ceramic.

Inlay - metallic - two surfaces.

Inlay - metallic - three or more surfaces.

Onlay - metallic - three surfaces.

Onlay - metallic - four or more surfaces.

The following services are limited to one time every 60 months.

Retainer crown - porcelain/ceramic.

Retainer crown - porcelain fused to high noble metal.

Retainer crown - porcelain fused to predominately base metal.

Retainer crown - porcelain fused to noble metal.

Retainer crown - porcelain fused to titanium and titanium alloys.

Retainer crown - 3/4 cast high noble metal.

Retainer crown - 3/4 cast predominately base metal.

Retainer crown - 3/4 cast noble metal.

Retainer crown - 3/4 porcelain/ceramic.

Retainer crown - 3/4 titanium and titanium alloys.

Retainer crown - full cast high noble metal.

Retainer crown - full cast predominately base metal.

Retainer crown - full cast noble metal.

The following services are not subject to a frequency limit.

Re-cement or re-bond fixed partial denture.

Core build up for retainer, including any pins.

Fixed partial denture repair necessitated by restorative material failure.

Oral Surgery

The following services are not subject to a frequency limit.

Extraction, erupted tooth or exposed root.

Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.

Removal of impacted tooth - soft tissue.

Removal of impacted tooth - partially bony.

Removal of impacted tooth - completely bony.

Removal of impacted tooth - completely bony with unusual surgical complications.

Surgical removal or residual tooth roots.

Coronectomy - intentional partial tooth removal.

Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.

Surgical access of an unerupted tooth.

Alveoloplasty in conjunction with extractions - per quadrant.

Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant.

Alveoloplasty not in conjunction with extractions - per quadrant.

Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant.

Removal of lateral exostosis (maxilla or mandible).

Incision and drainage of abscess.

Suture of recent small wounds up to 5 cm.

Collect - apply autologous product.

Bone replacement graft for ridge preservation - per site.

Buccal/labial frenectomy (frenulectomy).

Lingual frenectomy (frenulectomy).

Excision of pericoronal gingiva.

Adjunctive Services

The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit.

Palliative (Emergency) treatment of dental pain - minor procedure.

Covered only when Medically Necessary.

Deep sedation/general anesthesia first 30 minutes.

Dental sedation/general anesthesia each additional 15 minutes.

Deep sedation/general anesthesia - first 15 minutes.

Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes.

Intravenous conscious sedation/analgesia - first 30 minutes.

Intravenous conscious sedation/analgesia - each additional 15 minutes.

Therapeutic drug injection, by report.

Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).

The following are limited to one guard every 12 months.

Occlusal guard - hard appliance, full arch.

Occlusal guard - soft appliance, full arch.

Occlusal guard - hard appliance, partial arch.

Implant Procedures

The following services are limited to one time every 60 months.

Endosteal implant.

Surgical placement of interim implant body.

Eposteal implant.

Transosteal implant, including hardware.

Implant supported complete denture.

Implant supported partial denture.

Connecting bar implant or abutment supported.

Prefabricated abutment.

Custom abutment.

Abutment supported porcelain ceramic crown.

Abutment supported porcelain fused to high noble metal.

Abutment supported porcelain fused to predominately base metal crown.

Abutment supported porcelain fused to noble metal crown.

Abutment supported cast high noble metal crown.

Abutment supported cast predominately base metal crown.

Abutment supported porcelain/ceramic crown.

Implant supported porcelain/ceramic crown.

Implant supported crown - porcelain fused to high noble alloys.

Implant supported crown - high noble alloys.

Abutment supported retainer for porcelain/ceramic fixed partial denture.

Abutment supported retainer for porcelain fused to high noble metal fixed partial denture.

Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture.

Abutment supported retainer for porcelain fused to noble metal fixed partial denture.

Abutment supported retainer for cast high noble metal fixed partial denture.

Abutment supported retainer for predominately base metal fixed partial denture.

Abutment supported retainer for cast metal fixed partial denture.

Implant supported retainer for ceramic fixed partial denture.

Implant supported retainer for FPD - porcelain fused to high noble alloys.

Implant supported retainer for metal FPD - high noble alloys.

Implant/abutment supported fixed partial denture for completely edentulous arch.

Implant/abutment supported fixed partial denture for partially edentulous arch.

Implant maintenance procedure.

Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.

Implant supported crown - porcelain fused to predominantly base alloys.

Implant supported crown - porcelain fused to noble alloys.

Implant supported crown - porcelain fused to titanium and titanium alloys.

Implant supported crown - predominantly base alloys.

Implant supported crown - noble alloys.

Implant supported crown - titanium and titanium alloys.

Repair implant prosthesis.

Replacement of semi - precision or precision attachment.

Repair implant abutment.

Remove broken implant retaining screw.

Abutment supported crown - porcelain fused to titanium and titanium alloys.

Implant supported retainer - porcelain fused to predominantly base alloys.

Implant supported retainer for FPD - porcelain fused to noble alloys.

Implant removal.

Debridement peri-implant defect.

Debridement and osseous peri-implant defect.

Bone graft peri-implant defect.

Bone graft implant replacement.

Implant/abutment supported interim fixed denture for edentulous arch - mandibular.

Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

Implant supported retainer - porcelain fused to titanium and titanium alloys.

Implant supported retainer for metal FPD - predominantly base alloys.

Implant supported retainer for metal FPD - noble alloys.

Implant supported retainer for metal FPD - titanium and titanium alloys.

Implant index.

Semi-precision abutment - placement.

Semi-precision attachment - placement.

Abutment supported retainer - porcelain fused to titanium and titanium alloys.

Medically Necessary Orthodontics

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

All orthodontic treatment must be prior authorized.

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

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

The following services are not subject to a frequency limitation as long as benefits have been prior authorized.

Limited orthodontic treatment of the primary dentition.

Limited orthodontic treatment of the transitional dentition.

Limited orthodontic treatment of the adolescent dentition.

Interceptive orthodontic treatment of the primary dentition.

Interceptive orthodontic treatment of the transitional dentition.

Comprehensive orthodontic treatment of the transitional dentition.

Comprehensive orthodontic treatment of the adolescent dentition.

Removable appliance therapy.

Fixed appliance therapy.

Pre-orthodontic treatment visit.

Periodic orthodontic treatment visit.

Orthodontic retention.

Removal of fixed orthodontic appliances for reasons other than completion of treatment.

Repair of orthodontic appliance - maxillary.

Repair of orthodontic appliance - mandibular.

Re-cement or re-bond fixed retainer - maxillary.

Re-cement or re-bond fixed retainer - mandibular.

Repair of fixed retainer, includes reattachment - maxillary.

Repair of fixed retainer, includes reattachment - mandibular.

Section 12: Pediatric Vision Care Services

How Do You Use This Document?

This section of the Policy provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

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

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

Benefits for Pediatric Vision Care Services

What Are the Benefit Descriptions?

Network Benefits

Benefits - Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, you may call the provider locator service at 800-638-3120. You may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhc.com/exchange.

Benefits are not available for Vision Care Services that are not provided by a UnitedHealthcare Vision Network Vision Care Provider.

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

Routine Vision Exam

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

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point of convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

Eyeglass Lenses

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

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

Eyeglass Frames

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

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

Contact Lenses

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

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

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

Necessary Contact Lenses

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

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

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

Low Vision

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

Benefits include:

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

Payment Information

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

Annual Deductible

Unless otherwise stated, Benefits for pediatric Vision Care Services provided under this section are subject to any Annual Deductible stated in the *Summary of Benefits and Coverage ("SBC").*

Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this section applies to the Out-of-Pocket Limit stated in the *Summary of Benefits and Coverage ("SBC")*.

Pediatric Vision Exclusions

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

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-UnitedHealthcare Vision Network Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in this section under the heading *Benefits for Pediatric Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.
8. Orthoptics or vision therapy training and any associated supplemental testing.
9. Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK).
10. Contact lenses if an eyeglass frame and eyeglass lenses are received in the same calendar year.
11. Eyeglass frame and eyeglass lenses if contact lenses are received in the same calendar year.
12. Services or treatments that are already excluded in *Section 2: Exclusions and Limitations* of the Policy.

Claims for Low Vision Care Services

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

Reimbursement for Low Vision Care Services

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

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

Send the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the Policy:

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

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

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

Vision Care Service - any service or item listed in this section under the heading *Benefits for Pediatric Vision Care Services.*

Vision Care Service and Frequency of Service

Routine Vision Exam or Refraction only in lieu of a complete exam – once every 12 months.

Eyeglass Lenses (single vision, bifocal, trifocal, lenticular) – once every 12 months.

Lens Extras (polycarbonate lenses, standard scratch-resistant coating) – once every 12 months.

Eyeglass Frames – once every 12 months.

Contact Lenses and Fitting and Evaluation

- Contact Lens Fitting and Evaluation – once every 12 months.
- Covered Contact Lens Formulary – limited to a 12-month supply.

Necessary Contact Lenses – limited to a 12-month supply.

Low Vision Care Services (low vision testing, low vision therapy) – once every 24 months. Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us.

Section 13: Consolidated Appropriations Act Summary

The Policy complies with the applicable provisions of the *Consolidated Appropriations Act (the "Act") (P.L. 116-260)*.

No Surprises Act

Balance Billing

Under the Act, the *No Surprises Act* prohibits balance billing by out-of-Network providers in the following instances:

- When Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
- When non-Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described in the Act.
- When Emergency Health Care Services are provided by an out-of-Network provider.
- When Air Ambulance services are provided by an out-of-Network provider.

In these instances, the out-of-Network provider may not bill you for amounts in excess of your applicable Co-payment, Co-insurance or deductible (cost share). Your cost share will be provided at the same level as if provided by a Network provider and is determined based on the Recognized Amount.

If you get a bill from an Out-of-Network Provider under any of the above circumstances that you do not believe is owed:

- Call us first at the telephone number listed on the back of your ID card. We will try to the resolve the issue with the provider on your behalf.
- Contact the *New Mexico Office of Superintendent of Insurance* if the problem has not been resolved by us at https://www.osi.state.nm.us/pages/misc/mhcb-complaint or 1-855-427-5674.

You also have the right to contact the federal government by phone at 1-800-985-3059 or online at https://www.cms.gov/medical-bill-rights/help/submit-a-complaint.

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

Determination of Our Payment to the Out-of-Network Provider:

When Covered Health Care Services are received from out-of-Network providers for the instances as described above, Allowed Amounts, which are used to determine our payment to out-of-Network providers, are based on one of the following in the order listed below as applicable:

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

Continuity of Care

The Act provides that if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current

provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

Provider Directories

The Act provides that if you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), your cost-sharing will be no greater than if the service had been provided from a Network provider.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-569-3491 or visit uhc.com/xnm0001policy2025. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $4,750 Individual / $9,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes-Benefits available with no charge such as Network Preventive-care and Mental & Behavioral Health services are covered before you meet your deductible. The cost-sharing below indicates when the deductible does not apply for each benefit.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive-services without cost-sharing and before you meet your deductible. See a list of covered preventive-services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $9,200 Individual / $18,400 Family	The out-of-pocket-limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket-limits until the overall family out-of-pocket-limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket-limit.
Will you pay less if you use a network provider?	Yes. See Choice Network at uhc.com/xnmdocfindoa2025 or call 1-866-569-3491 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network-provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network-provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay /visit, deductible does not apply	Not Covered	No charge for anything related to COVID-19 screening, testing vaccines or medical treatment. You may be subject to additional facility/clinic fees. Please check with your provider.
	Specialist visit	$90 copay /visit, deductible does not apply	Not Covered	No charge for anything related to COVID-19 screening, testing vaccines or medical treatment. You may be subject to additional facility/clinic fees. Please check with your provider.
	Preventive care/ screening/ immunization	No Charge	Not Covered	No charge for anything related to COVID-19 screening, testing vaccines or medical treatment. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: Free Standing/Office: $15 copay /service, deductible does not apply Hospital: $75 copay /service, deductible does not apply X-Ray/Diagnostics: Free Standing/Office: 40% coinsurance Hospital: 50% coinsurance	Not Covered	No charge for anything related to COVID-19 screening, testing vaccines or medical treatment. You may be subject to additional facility/clinic fees. Please check with your provider.
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: 40% coinsurance Hospital: 50% coinsurance	Not Covered	You may be subject to additional facility/clinic fees. Please check with your provider.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Tier 1 - Zero Cost-Share Drugs	No Charge	Not Covered	Provider means pharmacy for purposes of this section. Retail: One month supply up to a 30-day supply or a 90-day supply at 2.5x the 30-day cost-share. Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost-share. Specialty drugs limited to a 30-day supply at a network pharmacy. Certain drugs may have a preauthorization requirement. Certain medications for preventive care, contraception, and behavioral health are
	Tier 2 – Preferred Generic Drugs	$3 copay /prescription, deductible does not apply	Not Covered	
	Tier 3 - Non-Preferred Generic, Preferred Brand Drugs	$55 copay /prescription	Not Covered	
	Tier 4 - Preferred	40% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
uhc.com/xnmdruglist2025	Specialty Drugs			covered at No Charge. Third party payments such as drug manufacturer's coupons are accepted and applicable rebated amounts will apply toward your cost-sharing. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Insulin products listed on the Prescription Drug List are covered at No Charge at a network pharmacy. Other covered insulin products will not exceed $25 for a 30-day supply at a network pharmacy.
	Tier 5 - Non-Preferred Brand Drugs	40% coinsurance	Not Covered	
	Tier 6 - Non-Preferred Specialty Drugs	50% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: 40% coinsurance Hospital: 50% coinsurance	Not Covered	You may be subject to additional facility/clinic fees. Please check with your provider.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Balance-billing is not allowed for out-of-network services.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Balance-billing is not allowed for out-of-network services.
	Urgent care	$60 copay /visit, deductible does not apply	Not Covered	Virtual visits - No Charge by a Designated Virtual Network Provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	None
	Physician/surgeon fees	40% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No Charge Intensive Outpatient: No Charge All Other Outpatient: No Charge	Not Covered	None
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost-sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care
	Childbirth/delivery professional services	40% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	40% coinsurance	Not Covered	may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Prior-authorizations for gynecological or obstetrical ultrasounds are not required.
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not Covered	Limited to 100 visits/year.
	Rehabilitation services	$45 copay /visit, deductible does not apply	Not Covered	Limits/year: Cardiac, Physical, Speech, Pulmonary, Occupational: Unlimited visits each
	Habilitative services	$45 copay /visit, deductible does not apply	Not Covered	Limits/year: Speech, Physical, Occupational: Unlimited visits each You may be subject to additional facility/clinic fees. Please check with your provider.
	Skilled nursing care	40% coinsurance	Not Covered	Skilled nursing is limited to 60 days/year.
	Durable medical equipment	40% coinsurance	Not Covered	None
	Hospice services	40% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam/12 months.
	Children's glasses	40% coinsurance	Not Covered	Limited to 1 pair/12 months.
	Children's dental check-up	No Charge	Not Covered	Limited to 2 visits/12 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion - (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Dental care (Adult)
- Glasses (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care - except as covered for certain diseases

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 20 visits/year, no limit for rehabilitation or habilitative treatment
- Bariatric surgery
- Chiropractic (manipulative) care - 20 visits/year, no limit for rehabilitation or habilitative treatment
- Hearing aids - 1 purchase per hearing impaired ear/36 months
- Infertility treatment - diagnosis and treatment of underlying causes
- Weight loss programs – limited to prescription drugs and programs for obesity

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: UnitedHealthcare of New Mexico, Inc. at 1-866-569-3491 or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or New Mexico Office of Superintendent of Insurance, 1120 Paseo De Peralta, Santa Fe, NM 87501, 1-855-427-5674 or osi.state.nm.us or Office of Personnel Management Multi State Plan Program: opm.gov/healthcare-insurance/multi-state-plan-program/external-review/ . Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com/exchange or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or New Mexico Office of Superintendent of Insurance, at 1-855-427-5674 or osi.state.nm.us.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-569-3491
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa1-866-569-3491
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-569-3491
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'1-866-569-3491

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,750
Specialist copayment	$90
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$4,750
Copayments	$200
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,110

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,750
Specialist copayment	$90
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$700

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,750
Specialist copayment	$90
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,400

UnitedHealthcare of New Mexico, Inc.

New Mexico Supplemental Summary of Benefits and Coverage

Services You May Need	Your Cost if You Use an In-Network Provider	Limitations & Exceptions
The following benefits are covered as specified to the right: • Clinical Trials • Dental Anesthesia and Dental Services-Accident Only • Gender Dysphoria • Temporomandibular Joint Syndrome (TMJ) • Transplantation Services	*Depending upon whether the service is rendered in a Physician's Office, an Inpatient Hospital or Outpatient Facility setting, Your Cost will be the same as those stated under each "Services You May Need" category in the Summary of Benefits and Coverage.*	Transplantation Services must be received from a Network Transplant Provider.
The following benefits are covered as specified to the right: • Scopic Procedures – Outpatient Diagnostic and Therapeutic • Therapeutic Treatments – Outpatient • Enteral Nutrition • Necessary Medical Supplies • Orthotics • Pharmaceutical Products – Outpatient	*Your cost will be the same as stated in the Facility Fee (e.g., ambulatory surgery center) category in the Summary of Benefits and Coverage.*	

Services You May Need	Your Cost if You Use an In-Network Provider	Limitations & Exceptions
The following benefit is covered as specified to the right: • Telehealth • Virtual Care Service	*Depending upon where Covered Health Care Service provided, Your cost will be the same as those stated under each "Services You May Need" category in the Summary of Benefits and Coverage*	Virtual Urgent Care is subject to no cost share on all non-standardized plans.
The following benefit is covered as specified to the right: • Diabetes Services	*Your cost will be the same as stated in the Durable Medical Equipment category in the Summary of Benefits and Coverage for all non-standard plans.*	Diabetes Services is subject to no cost share for "Clear Cost" standard plans.
The following benefits are covered as specified to the right: • Prosthetic Devices	*Your cost will be the same as stated in the Facility Fee (e.g., ambulatory surgery center) category in the Summary of Benefits and Coverage for all non-standard plans.* *Your cost will be the same as stated in the "Emergency Medical Transportation" category in the Summary of Benefits and Coverage for all "Clear Cost" standard plans.*	
The following benefits are covered as specified to the right: • Reconstructive Procedures	*Your cost will be the same as stated in the Facility Fee (e.g., ambulatory surgery center) category in the Summary of Benefits and Coverage for all non-standard plans.* *Your cost will be the same as stated in the "Emergency Room Care" category in the Summary of Benefits and Coverage on all "Clear Cost" standard plans.*	

Language Assistance Services

1-877-265-9199, TTY **711**

English: Translation services and interpreters are available at no cost to you. If you need help, please call the number above or the Member Services number on your health plan ID card.

Spanish: Hay servicios de traducción e interpretación disponibles sin costo para usted. Si necesita ayuda, llame al número anterior o al número de Servicios para Miembros que figura en la tarjeta de identificación de su plan de salud.

Chinese: 翻译服务和口译员免费供您使用。如果您需要帮助，请拨打上述号码或拨打您健康计划 ID 卡上的会员服务号码。

Vietnamese: Dịch vụ dịch thuật và thông dịch viên được cung cấp miễn phí cho quý vị. Nếu quý vị cần trợ giúp, vui lòng gọi số ở trên hoặc số bộ phận Dịch vụ Thành viên trên thẻ ID chương trình sức khỏe của quý vị.

Korean: 번역 서비스와 통역사는 비용 부담 없이 이용하실 수 있습니다. 도움이 필요하신 경우, 전술한 번호 또는 의료 플랜 ID 카드에 기재된 가입자 서비스 번호로 전화하십시오.

Arabic: تتوفر خدمات الترجمة والمترجمون الفوريون لك مجانًا. إذا كنت بحاجة إلى المساعدة، فيُرجى الاتصال بالرقم أعلاه أو رقم خدمات الأعضاء الموجود على بطاقة معرف الخطة الصحية الخاصة بك.

French Creole: Sèvis tradiksyon ak entèprèt disponib pou ou gratis. Si w bezwen èd, tanpri rele nimewo ki anwo a oswa nimewo Sèvis Manm ki sou kat idantite (ID) plan sante w la.

Tagalog: Ang mga serbisyo sa pagsasalin at mga tagapagsalin ay magagamit mo nang walang bayad. Kung kailangan mo ng tulong, mangyaring tawagan ang numero sa itaas o ang numero ng mga Serbisyo sa Miyembro na nasa iyong ID kard ng planong pangkalusugan.

French: Les services de traduction et d'interprétation vous sont fournis gratuitement. Si vous avez besoin d'aide, veuillez appeler le numéro ci-dessus ou le numéro de services aux membres figurant sur votre carte d'assurance maladie.

Russian: Вам доступны бесплатные услуги перевода и устные переводчики. Если вам нужна помощь, позвоните по указанному выше номеру или по номеру отдела обслуживания участников, указанному на вашей идентификационной карте программы страхования здоровья.

Polish: Mogą Państwo bezpłatnie skorzystać z usługi tłumaczenia pisemnego lub ustnego. Jeśli potrzebują Państwo pomocy, należy zadzwonić pod numer podany powyżej lub numer usług dla członków podany na karcie identyfikacyjnej członka planu ubezpieczenia zdrowotnego.

German: Übersetzungsdienste und Dolmetscher stehen Ihnen kostenlos zur Verfügung. Wenn Sie Hilfe benötigen, rufen Sie bitte die oben genannte Nummer oder die Nummer des Mitgliederservices auf Ihrer Versichertenkarte an.

Gujarati: અનુવાદ સેવાઓ અને દુભાષિયા તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. જો તમને મદદની જરૂર હોય, તો કૃપા કરીને ઉપરના નંબર પર અથવા તમારા હેલ્થ પ્લાન આઈડી કાર્ડ પરના સભ્ય સેવાઓ નંબર પર કૉલ કરો.

Urdu: آپ کے لیے بغیر کسی فیس یا اخراجات کے ترجمہ کی خدمات اور ترجمان دستیاب ہیں۔ اگر آپ کو مدد کی ضرورت ہو، تو برائے مہربانی اوپر دیئے گئے نمبر یا اپنے ہیلتھ پلان آئی ڈی کارڈ پر موجود Member Services کے نمبر پر کال کریں۔

Portuguese: Você tem à disposição serviços gratuitos de tradução e intérpretes. Caso precise de ajuda, ligue para o número acima ou para o número de Atendimento a Membros exibido em seu cartão de identificação do plano de saúde.

Japanese: 翻訳サービスと通訳サービスを利用できます。サポートが必要な場合は、上記の電話番号か、保険プラン ID カードのメンバーサービス番号に電話してください。

Hindi: अनुवाद सेवाएँ और दुभाषिए आपके लिए निःशुल्क उपलब्ध हैं। यदि आपको सहायता की आवश्यकता है, तो कृपया अपने स्वास्थ्य योजना आईडी कार्ड पर ऊपर दिए गए नंबर या सदस्य सेवा नंबर पर कॉल करें।

Persian: خدمات ترجمه کتبی و شفاهی به صورت رایگان برای شما فراهم است. اگر به کمک نیاز دارید، با شماره تلفن بالا یا شماره تلفن خدمات مشتری درج شده روی کارت شناسایی برنامه درمانی خود تماس بگیرید.

Amharic: የትርጉም አገልግሎቶች እና አስተርጓሚዎች ለእርስዎ ያለ ምንም ወጪ ይገኛሉ። እርዳታ ከፈለጉ፣ እባክዎን ከላይ ባለው ቁጥር ወይም በጤና እቅድ መታወቂያ ካርድዎ ላይ ባለው የአባላት አገልግሎት ቁጥር ይደውሉ።

Italian: Sono disponibili gratuitamente servizi di traduzione e interpreti. Se hai bisogno di aiuto, chiama il numero sopra oppure il numero di assistenza presente sulla tua tessera sanitaria.

Pennsylvania Dutch: Wann du Deitsch schwetzscht un Druwwel hoscht fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Wann du Hilf brauchscht, ruf die Nummer drowwe uff odder die Nummer fer Member Services as uf dei Health Plan ID Card is.

Navajo: Naaltsoos hazaad bee hadilnééh bee áka'anída'awo'í dóó ata' dahalne'í t'áá jiik'eh ná hóló. Shika'adoowoł nínízingo, t'áá shǫǫdí hódahdi námboo bikí'ágíí doodago Bił Ha'dít'éhí Bika'aná'awo' nits'íís bee ha'dít'éhí ID ninaaltsoos nitł'izí bąąh námboo bikí'ágíí bee hodíilnih.

United Healthcare®

Notice of non-discrimination

The company complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes.

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

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UTAH 84130

Email: **UHC_Civil_Rights@uhc.com**

If you need help with your complaint, please call toll-free **1-877-265-9199** or the toll-free number on your health plan ID card (TTY/RTT **711**).

You can also file a complaint with the U.S. Department of Health and Human services.

Online: **https://www.hhs.gov/civil-rights/filing-a-complaint/index.html**

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

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call toll-free **1-877-265-9199** or the toll-free number on your health plan ID card (TTY/RTT **711**).

This notice is available at **https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices**.

NOTICE OF
PROTECTION PROVIDED BY
NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000 ($500,000 for hospital, medical and surgical insurance policies).

Note to benefit plan trustees or other holders of unallocated annuities covered under the act: For unallocated annuities that fund certain governmental retirement plans, the limit is $250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under New Mexico law.

To learn more about the above protections, please visit the Association's website at www.nmlifega.org, or contact:

New Mexico Life Insurance
Guaranty Association
PO Box 2880
Santa Fe, NM 87504-2880
505-820-7355

New Mexico Office of the
Superintendent of Insurance
PO Box 1689
Santa Fe, NM 87504-1689
855-427-5674

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an

insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and New Mexico law, then New Mexico law will control.